

Chapter 1:

The Approach of the Thesis

The beginning of wisdom is found in doubting; by doubting we come to the question, and by seeking we may come upon the truth.
–Pierre Abelard

The problem explored and analysed in this study involves the experiences of five registered nurses and one enrolled nurse who were labelled whistleblower nurses by the Australian media. The participants of this study were all employees of the public health system in New South Wales, Australia. The person identified as 'Kathrine' is the researcher and author of this study, as well as a participant observer.

Theoretical Framework

To explore and understand the experiences of the participants of this study, a qualitative methodology was implemented using in-depth interviews. The participants, within a symbolic interactionist framework, were encouraged to explain how their experiences as nurses had led them to be labelled by the media and regarded by their colleagues as whistleblowers. This qualitative inquiry explores what it is to be a nurse, the concept of patient advocacy, the effects of bullying and harassment and the concept that qualities inherent in professional nurses underpin the compulsion for nurses to speak

out publicly. An attempt is also made to offer a professional definition of that which in other roles would be defined as whistleblowing.

To undertake research about nursing and whistleblowing, it is necessary to explore how nurses work and why they behave as they do. For the research to reflect that which truly represents nursing, it is essential to acknowledge the existing social, cultural and political imperatives that have historically underpinned the profession. From this knowledge an appropriate qualitative research framework and methodology can be constructed. Stubblefield and Murray (2002), in support of this approach, warn there may be a flaw in qualitative studies if the method applied to the study is not linked or guided by the philosophical underpinnings of the research group.

Nursing is described by Lopez and Willis (2004) as an art and a science that concerns itself with human interaction and specialised knowledge that has been drawn from lived experience, contextual realities and concern for those to whom they offer care. It would seem the most appropriate nursing research methods are, as described by Greene and Caracelli (1997), dialectical – that is, adopting a methodology to arrive at the truth by the exchange of logical arguments. This point of view embraces the premise that philosophical differences in human inquiry are real and, while sometimes not easily reconciled (Shaw, 2003), they represent the inherent differences and contradictions humans express in their everyday lives.

The acceptance of human interaction and its associated meanings guides the researcher towards

a balanced reciprocal relationship between philosophy and methodology, between paradigm and practice. This ... honours both the integrity of the paradigm construct and the legitimacy of contextual demands and seeks a respectful, dialogical interaction between the two in guiding and shaping evaluation decisions in the field. (Greene & Caracelli, 1997, p. 17)

Interpretive theories such as phenomenology and symbolic interactionism are well suited to nursing research for they promote 'understanding unique individuals and their meanings and interactions with others and the environment' (Meleis, 1996, p. 2). Specifically, according to van Manen (1990), phenomenology promotes borrowing human experience to promote understanding of human interactions and behaviours for the researcher. McConnell-Henry, Chapman and Francis (2009b) confirm the application of phenomenological inquiry is appropriate where human experience is central to the research question. History and the literature confirm there have been considerable phenomenological approaches to the study of nursing. Examples include Grover (1996), Robertson-Malt (1999), J. Madison and Minichiello (2000), Crist and Tanner (2003), Lopez and Willis (2004), McConnell-Henry, Chapman and Francis (2009a) and Garrett, Chan, Brykczynski, Malone and Benner (2010).

The term symbolic interactionism was credited in 1934 to George Herbert Mead; in 1969, it was developed by Herbert George Blumer, a student of Mead's, to offer perspective to the way in which humans conduct their daily lives in conjunction with others (Shaw, 2003). Van Manen (1990) cited Blumer who declared symbolic interactionism to be underpinned by three core principles. First is meaning: 'humans act towards things on the basis of the meanings they ascribe to those things'. Second is language: 'the meaning of such things is derived from, or arises out of, the social interaction one has with others and the society'. Third is thought: 'these meanings are handled in, and modified through, an interpretive process used by the person in dealing with the things he/she encounters' (p. 2).

Merton (1995) cited Thomas and Thomas (1928) who famously asserted 'If men define situations as real, they are real in their consequences' (p. 572). In other words, the interpretation of the context of the situation pre-empt individual reaction which is the result of subjective perception(s) of the situation. Symbolic interactionism theory argues humans are social beings, and as such are inseparable from the society in which they exist. According to Meltzer, Petras and Reynolds (1975), human behaviour is not determined by instinct, but rather by reflective, socially-driven interpretation of life experiences. Charon (2007), in support of this statement, says human objective reality is created out of social reality – the reality that is learned from others and their common surroundings.

The theory of symbolic interactionism is an appropriate framework to apply to the way nurses learn, work and socialise as a group. Nursing education in developed countries is offered via tertiary facilities with degree status awarded to successful candidates. Benner (1994), in her landmark study, describes how nursing students, through exposure to nursing culture, develop 'nursing connoisseurship' – a trait developed by the acquisition of expertise. Benner contends nursing students learn to recognise and describe 'the context of meanings, characteristics and outcomes of their connoisseurship' (p. 5). Nursing students learn about nursing culture and clinical practice from exposure to other nurses and actual clinical experience. The learning experience of nurses is, adds Holland (1999), a stepped process with rites of passage – 'separation, transition and incorporation' (p. 229).

As nurses progress from students to neophytes to skilled clinicians, they migrate from the periphery of nursing practice to the central margins of nursing culture. Postgraduate nurses must learn to perform as clinicians within the defined clinical culture of the health care system if they are to be accepted into the dominant nursing culture of the employing organisation. Farrell (2001), in support of this argument, confirms nursing culture precipitates horizontal and vertical violence and poor colleague relationships. It was also stated 'junior nurses are quickly socialised into a culture of nurse-to-nurse abuse' (p. 28). This behaviour serves to validate the nursing

hierarchy and promote the status quo. Successful negotiation of the rites of passage and espousal of behaviours to act like a nurse seem pivotal if the new graduate is to be accepted into the wider nursing social group. Failure to adopt the values and attitudes of more senior nurses promotes isolation and 'social limbo' for neophytes (Grover, 1996, p. 56). Duffy, McCallum, Ness and Price (2012) concurred that the need to fit into the social nursing group can be to the detriment of the neophyte. Where a workplace has an absence of role models who report poor practice, it is unlikely the neophyte will act outside of the group norm.

Nurses define their culture by their attitudes and their actions. There are boundaries that are tacitly accepted in the nursing profession. Whistleblower nurses, regardless of their intentions to protect their patients, by virtue of making public declarations of concern about patient care or safety violate nursing cultural norms and boundaries. Their actions, whether of advocacy or moral principle, attract criticism from the nursing profession; the whistleblower is then marginalised and treated as a professional pariah (Rosen, Katz, & Morahan, 2007).

A great deal has been written about the experiences of nurses who have spoken out publicly regarding matters of professional conscience (Faunce, Bolsin, & Chan, 2004), patient advocacy (Chafey, Rhea, Shannon, & Spencer, 1998), perceived poor or adverse patient outcomes (Mesmer-Magnus & Viswesvaran, 2005) and ethical decision-making (Ahern &

McDonald, 2002). Berry (2004) aptly defines whistleblowing as 'an avenue for maintaining integrity by speaking one's truth about what is right and what is wrong. It is a strategy for asserting rights, protecting interests, influencing justice and righting wrongs' (p. 1). This study adds to that body of literature. It describes the work context, experience and roles each nurse held at the time of the whistleblowing incident. There is an attempt to define and understand the nurses' individual belief systems and align these beliefs with the reasons behind why each participant felt compelled to speak publicly. This study also attempts to capture the reasons why six experienced nurses, despite the consequences, chose to speak out to protect their patients.

Statement of the Problem

Five registered nurses and one enrolled nurse employed within the public health system of New South Wales, independently of each other, raised concerns regarding their perceptions of inadequate patient treatment, poor patient outcomes and unexpected patient deaths via the management channels within their employing hospitals. The process for reporting of patient care concerns is linear, beginning with the local manager and where necessary escalated to more senior management personnel. The perceived failure of these organisations to act upon these reports was the catalyst for the nurses to raise patient care concerns outside the usual chain of command.

In this study, the terms whistleblower/informant and patient advocate are at times used interchangeably. Outside of nursing, public declaration of hospital events by an employee, may be interpreted as whistleblowing, as opposed to patient advocacy.

Terms such as mobbing/bullying/harassment/workplace violence and lateral aggression are used in this thesis to exemplify the extreme spectrum of consequences endured by nurses who publicly advocate for their patients.

Assumptions and Limitations

This research project is limited to the experience of six participants, and makes comparisons with similar studies of the lived experiences of whistleblower nurses. There is an assumption professional integrity and personal belief systems underpinned each whistleblower nurse's actions when they chose to speak out publicly about their patient care concerns. There is also an assumption each of the nurses was aware of the consequences of speaking out publicly and what that might entail (B. Berry, 2004; Faunce et al., 2004). Therefore, given their prior knowledge of treatment of whistleblower nurses and the individual experiences of these participants, the question must be asked: why do nurses choose to blow the whistle and make public their professional concerns? This project is relevant. In 2003, whistleblower allegations of inadequate or improper care within three public hospitals led to six major investigations including two by the Health Care Complaints Commission (HCCC), an Independent Commission

Against Corruption (ICAC) investigation and an inquiry by the NSW Medical Registration Board. Various other committees examined coronial referrals and hospital protocols and procedures. In June 2004, 15 doctors and 11 nurses were referred to the HCCC where allegations of improper care and poor safety standards were investigated (Pain, 2006). Findings of the Commission in 2003 upheld nurses' evidence of poor patient outcomes and unexpected deaths, and determined the quality of care delivered within the nominated hospitals was significantly deficient in term of its standards of care. The nurses who gave evidence experienced criticism, loss of employment and loss of expected career paths, and were ostracised and marginalised by their peers, supervisors and health system employers.

It is hoped this study will facilitate a fuller understanding of how the actions of six nurses served as the catalyst for the establishment of formalised clinical governance structures for each of the (then eight) Area Health Services in New South Wales. Additionally, this study will analyse the personal and professional costs to each nurse for her part in instigating investigation and improvement of clinical governance standards for public hospitals in New South Wales.

Study Objective

The objective of this study is primarily to explore and understand the individual experiences of six nurses employed within three hospitals in New

South Wales when they disclosed sentinel events from their workplace to the Australian media. It is also important to understand their reasons for speaking out. It is hoped this study will promote understanding of the experiences of nurses who advocate for patients and then are labelled as whistleblowers. It will become apparent the New South Wales State Government needs to address issues of protected disclosure for nurses. It is also long past due that the whistleblower laws of this state are addressed and refined to protect people who make public disclosures.

Chapter 2 provides a detailed literature review of contemporary writings, research and knowledge of the issues that are significant to nurses who choose to speak out about organisational problems, patient safety and other advocacy issues. Chapter 3 describes the methodology employed in this research. Chapter 4 includes a dialogue of the narratives from the first round of interviews as well as discussion and analysis of the early sequences of events. Chapters 5 and 6 include dialogue excerpts from the second and third rounds of interviews, which scrutinise the participants' views and experiences over time. Chapter 7 includes reflections, conclusions and recommendations for change.

Conclusion

This research challenges the concept that nurses who speak out are whistleblowers. Nurses who are labelled as whistleblowers must be protected if they are to perform their most vital role – that of patient advocacy. To act

as an advocate for patients is a demand society makes of nurses. It is imperative nurses of the future are prepared to interact with the media; but to avoid the tyranny of sensationalism, exposure, labelling and professional ruin, they must, as part of their degree status, learn the behaviours of the media-savvy. Health care organisations throughout Australia need consistent policies that will support nurses who have spoken out. Government legislation must underpin healthcare policies and hold organisations accountable if nurses are mistreated or abused as a result of their declarations. However, it is through education the greatest gains will be made in supporting and encouraging nurses to advocate for their patients. Forewarned is forearmed. From the outset of nursing education, the concept of ethical behaviour, advocacy and dealing with bullying and harassment must feature prominently as important information for nursing and health care management students. While rhetoric criticising the bullying and harassment of nurses is commonplace, there is little understanding of why nurses behave as they do towards colleagues who speak out to protect patients. Nurses of the future need education, tools and skills to move from rhetoric to understanding.

Chapter 2:

Literature Review

Great spirits have always found violent opposition from mediocrities. The latter cannot understand it when a man does not thoughtlessly submit to hereditary prejudices but honestly and courageously uses his intelligence.
-Albert Einstein

To understand why the participants of this study spoke publicly about their concerns with patient care and patient outcomes, it is necessary to understand the context: what it is to be an Australian nurse, how the Australian health care system functions and how the inherent values of being a nurse impact upon decision-making. This review explores the literature associated with the actions of and consequences for employees who speak out, making allegations that practices such as fraud, oversight of health and safety issues, negligence, malpractice or theft have occurred in their workplaces. Whistleblowing is described by Wilmot (2000) as 'the public exposure of organisational wrongdoing' (p. 1052). While the subject matter of this research concerns healthcare in New South Wales (NSW) Australia, consideration is given to other instances of whistleblowing across other professions. The purpose of this panoramic view is to demonstrate whistleblowing, or speaking out against a perceived wrongdoing, is neither

limited to nor peculiar to healthcare, but rather is a phenomenon that occurs when employees feel compelled to publicise their version of the truth when legitimate workplace processes fail them.

Australia, the Democratic Nation

Australia is a geographically substantial island continent, with a relatively small yet diverse population which, according to the Australian Bureau of Statistics, on 30 September 2010 comprised 22,408,000 people (2010a). Williams, Chaboyer and Patterson (2000) confirm Australia is a member country within the British Commonwealth, and has adopted the Westminster system of government at the federal level, with six state and two territory governmental authorities. In 1901 the states, formerly British Colonies, agreed to federate and declared themselves a Commonwealth. Australia, unlike Britain, has a constitution, with State parliaments subject to the national constitution. Federal law overrides any state law not consistent with the constitution (Australian Department of Foreign Affairs and Trade, 2007).

The Australian Health Care System

The Australian health care system consists of a combination of government and private initiatives, with government responsibilities divided between the federal and state authorities. Medicare is the publicly funded universal health insurance scheme that provides health care for all Australian citizens (Williams et al., 2000). In 2005–2006, the Australian federal government

funded 41.5% of health care expenditure, with the states and territories funding the residual 50.6%. The balance of funding for health care was derived from private health insurers and from individuals who incur out-of-pocket costs when they elected to be treated as private patients. It is estimated the total expenditure on health care during this period was \$86,879 million, or 9% of the GDP (Australian Institute of Health and Welfare, 2008, p. 396).

In 1984 a compulsory Medicare levy was imposed upon the Australian population as part of the Australian government's funding of health care from general revenues. The levy was originally set at 1.0% of taxable income. The levy has increased several times, and in 1997 a surcharge of 1.0% was imposed for high income earners, defined to include the very wealthy and at the lower end of the earning threshold, single individuals who earned \$50,000 or more or couples with a combined income of \$100,000 or more per year and who did not hold private health insurance for hospital care (Australian Institute of Health and Welfare, 2008, p. 401). Harrigan (1994) states the Australian Medicare scheme is faltering because of the aging population, the reluctance of the young to pay for private health care and the withdrawal of others from private health insurance because of the exponential rise in private health care costs, which are additional to the imposed Medicare levy upon taxpayers.

The Australian health care system is perceived by many as under-funded and it has undergone significant reform in the last decade. Significant cuts to funding, along with imposed efficiency gains, have affected all hospitals nationally. The concept of doing more with less in health care has seen the introduction of diagnosis-related groups (DRGs) and case mix funding, which according to Oats, Murray and Hindle (1998, p. 243) has resulted in 'radical changes to clinical practice and management, with significant reductions in patient length of stay' (p. 243). Harrigan (1994) in response to imposed cost control measures states the effect of DRGs and case mix funding has been an increased demand for health care while hospital services have been allowed to deteriorate.

Leeder (1998, p. 1572) likens the Australian health care system to the horse racing term 'two bob each way', meaning there is insufficient confidence in either horse to win so money is placed on the horse to win *or* take a place, ensuring some returns for a second or third placing. He further states, while health care expenditure is capped and prices are controlled for specialist services, there is little control on the volume of services provided, leading to a propensity to wastefulness through over-servicing. In 2006, the Medicare watchdog, Tony Webber, Federal Director of the Professional Services Review, voiced concern that big medical centres have the potential to exploit Medicare's \$9 billion a year in benefit payouts (Metherell, 2006, p. 11): evidence was emerging that doctors working for corporatized medical chains

had software and patient management systems that could maximise returns from Medicare. He noted there is evidence some of their services, including pathology and radiology, are inappropriate (Kirk, 2008). It was further stated in 2005 there had been a 111% rise in the cost of general practitioner-prescribed Medicare-funded procedures (Edwards, 2008); raising questions about the relevance of services being ordered and whether all such services were needed.

Discussion regarding the Australian health care system would not be complete without acknowledgment of the inequities applicable to the Aborigines, Australia's Indigenous population. As of 30th June 2006, the Aboriginal and Torres Strait Islander population was estimated to be 517,000 or 2% of the total Australian population (Australian Bureau of Statistics, 2010b). The plight of the Australian Aboriginal population is, as described by Siegal (1995), subject to 'the power and hegemony of whiteness, ensuring dominance through social, economic and legal practices' (p. 158). Australian Aborigines experience morbidity and mortality rates considerably higher than non-Indigenous groups. The Australian Institute of Health and Welfare (2008) noted in 2004-05 'recurrent expenditures on health for Indigenous peoples was estimated at \$2,304 million or nearly 3% of recurrent health expenditure for the entire population. This spending equates to average spending of \$4718 per Indigenous person, 17% higher than the average \$4019 spent on other Australians' (p. 406-407). While

spending and health programs are targeted at improving the health status of Indigenous people, the interactions of non-Aboriginal policy makers do not fit well with the social and physiological attributes of Indigenous culture. Lisa Jackson Pulver of the Muru Marri Indigenous Health Unit at the University of New South Wales compiled a report titled *Aboriginal Health 2006* (Australian Institute of Health and Welfare, 2006a) that identified cultural disposition, dislocation of communities, cultural inappropriateness, socio-economic inequity and increased disease-specific risk factors as contributory to increased morbidity, mortality and suffering for Australia's Indigenous population.

Distributive Justice in Health Resource Allocation

Sprung, Eidelman and Steinberg (1997) describe a shift in modern health care from a single-patient focus to that of utilising the principles of distributive justice in the allocation of health care for the good of society as a whole. Spicer (2008) asserts within a finite resource environment such as health care, resources should be shared equitably and that resource allocation should be subject to the principles of distributive justice, which is achieved by four possible approaches:

By democratic allocation whereby the people or a representative body makes the decisions about how the health budget should be allocated ... On the grounds of age there are two opposing Australian Federal Government arguments. Firstly the concept of a "fair innings" whereby

resource allocation aims to offer each individual a fair life term as opposed to restriction or withdrawal of resources beyond a defined arbitrary age range ... On the basis of personal responsibility whereby a person, by their own actions i.e. smoking or obesity suffers lifestyle diseases is therefore less entitled to treatment by virtue of their lifestyle choices ... [and] On the basis of cost utility, a contentious economic measure of resource allocations. (p. 48)

Spicer (2008) notes at present, 'the most commonly used indicator is the Quality Adjusted Life Year (QALY) which makes assessment of the value treatments bring in terms of the added life benefits they bring about' (p. 48).

The Australian Nursing Profession

Today, the expansion of professional careers available to women beyond teaching, nursing and childcare, means nursing no longer has the appeal it once had as a career for women. Williams, et al. (2000) cite lack of remuneration and recognition as contributing to the dwindling interest in nursing and a nationwide shortage of nurses and midwives. Hegney and McCarthy (2000) note this shortage is particularly noticeable in rural and remote areas in Australia. As a result of ineffective recruitment and retention strategies, nursing shortages have been met with the introduction of unlicensed caregivers who undertake the less complex tasks previously undertaken by professional nurses (Gleeson, 1998; Williams et al., 2000). Historically, state and territory authorities have been responsible for their

own nursing workforce needs, and Williams et al. (2000) suggest this has led to duplication in the effort to attract nurses, increased national costs for nursing recruitment and retention and competition between states and territories.

There are two types of nurses in Australia – registered nurses and enrolled nurses (the equivalent of a practical or vocational nurse in other countries). In May 2007, The Australian Nursing Federation conducted a national survey of Australia's nursing profession. Four hundred and fifty-four nurses responded to the survey, which was considered a reasonable representation of respondents.

The Australian Institute of Health and Welfare (2006b) cited by the Australian Nursing Federation (2007) survey confirmed, of the nurses who responded, 83.3% were female and 16.7% were male; 54.6% were aged between 46 and 60 . These demographics are consistent with those reported by the Nursing and Midwifery Labour Force Survey (Australian Institute of Health and Welfare, 2008, p. 2) which confirmed a year later that females make up 90.6% of employed nurses in Australia (slightly reduced from 91.3% in 2004).

Australia, like the rest of the developed world, has an aging population that includes an aging nurse population. The Australian nursing workforce in 2001 was described as exhibiting a mean age of 40 and above (Brownson &

Harriman, 2001; Coffee-Love, 2001) The Nursing and Midwifery Labour Force Survey (2008a) noted the proportion of nurses aged 50 years and over increased from 29.7% to 34.9%. In 2008 the Australian Institute of Health and Welfare report confirmed 16% of all employees involved in Australian health care are aged 55 years or older.

Definition of an Enrolled Nurse

An enrolled nurse is a nurse who through one of the Department of Education and Training's (DEET) Technical and Further Education (TAFE) facilities has completed twenty-seven competency units and one clinical practice placement unit (TAFE NSW, 2009). The Australian Nursing Federation (2007) policy concerning nursing education and the enrolled nurse stipulates enrolled nurses are required to work under the direction and supervision of a registered nurse. The level of supervision may be direct or indirect, depending upon the nature of the work.

Scope of Professional Practice for Nurses

The scope of enrolled nurse practice has historically expanded and contracted according to the labour market. It is the often nebulous nature of these practice boundaries, as described in the study by Milson-Hawke and Higgins (2003), that causes enrolled nurses to make judgments about 'doing the work without overstepping the mark' (p. 44). However, this study which is inclusive of an enrolled whistleblower nurse confirms enrolled nurses

frequently determine their own scope of practice and undertake nursing practices that are beyond their level of education, preparation and training.

Gibson and Heartfield (2003) note over the last decade, Australia, like the rest of the developed world, has experienced a decline in the overall numbers of nurses in the health workforce. Enrolled nursing, often described as the second-level nurse, in many countries is no longer recognised as a legitimate nursing role. In Australia, recent research indicates the enrolled nurse role, though contentious, remains a core component of the health care workforce. McEwan (2008) sees the enrolled nurse as an integral member of the Australian health workforce, and notes the role of enrolled nurses is expanding in many practice settings. Medication administration is increasingly being delegated to enrolled nurses, raising issues related to role, scope of practice, educational preparation, competence and delegation and supervision of nursing activities.

McEwan (2008) demonstrates there is considerable variation in practice expectations between jurisdictions, individual health care settings and, on a daily basis, clinical practice. The literature (Gibson & Heartfield, 2003; Gibson & Heartfield, 2005; Milson-Hawke & Higgins, 2004; Stringer, 2006) reveals a wide range of practice settings for enrolled nurses, with inherent role diversity prompting variation in the scope of practice between employing Australian states and territories, metropolitan and regional areas, rural and remote settings and employing agencies (Australian Nursing

Federation, 2005). It is therefore not surprising that confusion and blurring of practice boundaries has occurred, and that a similarity is perceived between the role of the registered nurse and that of the enrolled nurse (Gibson & Heartfield, 2003; Gibson & Heartfield, 2005; Milson-Hawke & Higgins, 2003; Stringer, 2006).

A tenet of professionalism in nursing is the uniqueness nurses bring to and demonstrate in their work (Nurses Board of South Australia, 2003, p. 66). Workforce shortages and pressures have forced enrolled nurses to expand their scope of practice beyond their educational preparation and level of competence, without appropriate post-graduate education or professional development (Gibson & Heartfield, 2005; Milson-Hawke & Higgins, 2003, 2004). There is also a demand by registered nurses for enrolled nurses to work outside of their scope of practice (Gibson & Heartfield, 2005; Heartfield & Gibson, 2005; Milson-Hawke & Higgins, 2004), in order to meet the immediate needs of the patient because there is no one else to do the work; and often enrolled nurses willingly work outside a reasonable scope of practice in order to maintain a harmonious workplace or because they feel too uncomfortable or intimidated to decline. It may also be enrolled nurses undertake work outside of their scope of practice when their tenure as a nurse is equated by some enrolled nurses with a professional right to perform the work. Blurring of practice boundaries is an issue for the profession of nursing, and is not limited to the practise of enrolled nurses.

Titles such as *Clinical Nurse Specialist* and *Nurse Practitioner* are labels applied to advance-practice registered nurses. A. Kelly (2004) asserts the numerous titles appointed to registered nurses suggests specialisation which potentially serves to blur the boundaries of professional practice. McCabe and Burman (2006) agree advanced nursing practice may render nurses unable to 'see the line' that marks the boundaries of lawful and professional nursing practice (p. 6). The expansion of the scope of practice of registered nurses, according to Keeling (2004), at times encroaches upon medical care of the patient.

The Obedient (Nurse) Employee

In western societies, M. Johnstone (1994, p. 137) notes, a nurse's primary responsibility is to the patient. Ahern and McDonald (2002) concur with this, adding the code of ethics held by nurses binds them to report events when patient care is compromised or patient safety is jeopardised. In keeping with the mandate that all nurses are professionally bound to protect the patients under their care, in 1893, Lystra Gretter, a nurse educator from the old Harper Hospital in Detroit, Michigan, composed the Nightingale Pledge, an adaptation of the Hippocratic Oath, which among other imperatives states nurses will devote themselves to the welfare of those committed to their care:

I solemnly pledge myself before God and in the presence of this assembly, to pass my life in purity and to practice my profession

faithfully. I will abstain from whatever is deleterious and mischievous and will not take or knowingly administer any harmful drug. I will do all in my power to maintain and elevate the standard of my profession and will hold in confidence all personal matters committed to my keeping and all family affairs coming to my knowledge in the practice of my calling. With loyalty will I endeavour to aid the physician in his work and devote myself to the welfare of those committed to my care. (Gretter, 1893)

It could be argued while the Nightingale Pledge altruistically calls for devotion to the welfare of the patient, it also demands the nurse must abstain from whatever is deleterious (to whom is not stated: deleterious to the patient? to other nurses? to doctors?) The pledge also states nurses will 'hold in confidence all matters committed to my keeping'. Was Nightingale (or Gretter) prudently referring to the requirement for patient confidentiality, or is there an underlying suggestion that nurses should not reveal any information but unquestioningly maintain their silence about patient care and patient outcomes? Is it possible the Nightingale Pledge defers to doctors, promoting a requirement for all nurses of the time to maintain their silence and not speak out regardless of the circumstance?

Professional Nursing Practice – the Historical Context

Florence Nightingale in 1900 identified the need for knowledge that was specific to the practice of nursing. M. Roberts (1963) points out 'in countries where medicine is highly developed and nursing is not, the health status of

the people does not reflect the advanced stage of medicine' (p. 597). In the 1920s it was apparent, according to Rawnsley (1972), that nursing education focused more on the principle of obedience: that is, to unquestioningly execute the doctors' orders as opposed to actively participating in health promotion or in the reduction of health-related problems. It is clear from the literature that Nightingale demanded nurses be separate from, but subservient to, doctors. Selanders and Crane (2012) stated Nightingale 'valued egalitarian human rights and developed leadership principles and practices that provide useful advocacy techniques for nurses practicing in the 21st century'. She also expected nurses to be intelligent and attend patients diligently and to maintain the principles of hygiene and cleanliness. She was, however, not a woman to support the notion of blind faith in doctors. Black (2004) quotes Nightingale as having said, 'being obedient is a good quality for horses and dogs but not for nurses' (p. 37). Nevertheless, she demanded nurses be subservient to doctors, a position criticised by nurses of the future. Formal nursing education at this time was of low priority, with long hours of clinical work being the only real expectation of nursing's forbears. Dugan (1970) argues bureaucracy is a significant deterrent to the development of professional, autonomous nursing practice. The militaristic, hierarchical structure of nursing practice imposes significant limitations on how nursing practice should be delineated, perhaps at the expense of actions that reflect

intelligent, scientific, primary nurse assessment in pursuit of patient wellbeing.

It is important to understand the social factors that have influenced the protracted attainment of a professional status for nursing. Mary Roberts (1963), an American nurse historian, identifies four major factors responsible for the evolution of nursing: Christianity, wars, biology and social demands. Wars gave rise to the need for nursing; someone had to care for the sick, wounded and dying (pp. 58-69). It seems nursing's militaristic and secular beginnings promoted nurses as doers, not as scientific thinkers or problem solvers. Christianity and social need inspired nursing to adopt a nurturing, caring, surrogate mother image. The lack of formal nurse training and education created an impression of the nurse as a helper, performing the work assigned by other legitimate professionals such as doctors. Nursing was perceived to be limited to execution of unpleasant or menial tasks such as 'washing, cleaning away vomit and excreta and feeding', which according to Bradshaw (2000) are deeds regarded as acts of virtue requiring nothing more than 'goodness of character' (p. 325). Maas and Jacox (1997) concurred with this conjecture, which they say has largely influenced the universal perception of nurses as 'pseudo-professionals' (p. 5).

According to Maas and Jacox (1997, pp. 3-6) the hierarchical order under which nurses work has served to erode individual nurse accountability.

Individual nurses who deliver care are not responsible for participating in decision-making regarding patient wellbeing; such decisions are made and overseen by the nurse in charge of the shift. Maas and Jacox contended this inherent lack of accountability contributes to substandard care because 'everyone's job is no one's job, with responsibility for patient care being diffused throughout the nursing staff' (p. 5).

Hogg, Terry and White (1995) note social identity theory can be applied to this type of role-related behaviour, for this conjecture explains how decisions are made through group processes and interactions. 'This theory places its major theoretical emphasis on a multifaceted and dynamic self that mediates the relationship between social structure and individual behaviour' (p. 255). While group process and interactions are fundamental to nursing practice, the individual may not be able to express themselves because of the inherent hierarchical structure that dominates nursing practice.

Mascord (1992) confirmed in the early 1980s nursing education in Australia was transferred from hospital-based, apprenticeship-type training to universities where tertiary qualifications replaced certification of registered nurses. Nurse academics lobbied for increased accountability and autonomy of nursing practice, based on the argument that nursing is clearly and distinctly different from the discipline of medicine. Nursing is a profession in its own right, grounded in theory and science. This demand for legitimate professional status for nurses has prompted an increase in professional

autonomy with an expectation of legal, ethical and moral accountability and decision-making at an individual level that is reflective of patient advocacy. It was the transfer of nursing education to degree status achieved within universities that was fundamental to nursing being viewed as a profession instead of a role that offered an extension of womanly care.

Nursing Codes of Ethical Practice

The Code of Ethics for Nurses in Australia states nurses actively participate in minimising risks for 'self, health consumer, colleagues and community,' by supporting quality practice environments (Australian Nursing and Midwifery Council, 2008a, p. 3).

Nurses question and, when necessary, report to an appropriate authority, any nursing or health care issue they consider on reasonable grounds to be unethical, unsafe or illegal. Value statement 6 of the Code of Ethics for Nurses in Australia states:

valuing a culture of safety involves nurses actively engaging in the development of shared knowledge and understanding of the crucial importance of safety in contemporary health care. Nurses who value a culture of safety, appreciate that safety is everyone's responsibility. Nurses support the development of risk management processes and a practice environment designed to reduce the incidence and impact of preventable adverse events in health care. Nurses also support the open disclosure of any adverse events to any person affected during

the course of their care. (Australian Nursing and Midwifery Council, 2005, p. 9)

The question must be asked: if the nurse has reported to ever higher 'internal' authorities issues of concern regarding patient safety and patient outcomes and that authority does not act upon those concerns to protect the patient, how can the nurse be condemned for exercising a professional, ethical imperative? At what point in the escalation of health care concerns does the nurse metamorphose from advocate to whistleblower?

Nurses and Ethical Decision-making

The ways in which nurses make judgements regarding ethical practice are as diverse as they are complex. Vaartio, Leino-Kilpi, Salanterä and Tarja (2006) state:

nursing advocacy is an inherent element of professional nursing ethics and is defined as an integral part of a nurse's efforts to promote and safeguard the well being and interests of his/her patients or clients by ensuring they are aware of their rights and have access to information for informed decisions. (p. 283)

However, ethical decision-making for nurses is influenced by cultural, ethnic and socio-demographic data such as education level, age and gender when considering attitudes towards patient autonomy and informed consent (Okasha, 2000). The role of the nurse is to provide holistic care. The nurse does not focus singularly on affected body parts, as might be expected of a

surgeon. When nurses make decisions they include considerations of age, gender, ethnicity and language skills, which, when combined with knowledge of specific ethnic group practices, promotes communication and understanding for patients and their families (Okasha, 2000).

In a complex multicultural nation such as Australia, implementation of codes of ethical practice can be tricky, with individual, familial and community requirements frequently in conflict with the social position of the medical doctor. Within some ethnic groups, family consultation is central to any discussion of procedures or outcomes, and even of the delivery of informed consent. Family elders may make health care decisions for ailing relatives, or the medical doctor may be viewed as the unquestioned authority. Departure from the usual cultural decision-making model can plunge families into chaos. According to Okasha (2000), religion and social norms are central to the social lives and beliefs of numerous diverse populations.

Oppenheim and Sprung (1998) describe inherent differences in the evolution of western and eastern societies in terms of regard for privacy, confidentiality and decentralisation in some aspects of life. Barry (1988) and Ip, Gilligan and Koenig (1998) expand upon other cultural differences between populations, including variations in the view of patient autonomy, informed consent and the right to question or to litigate against the medical profession. Such literature confirms cultural differences promote unique concepts and expectations held by individual populations. For example,

Barry (1988) points out that Chinese and other ethnic cultural differences associated with Taoism and Confucianism emphasise 'acceptance of fate, harmony, interpersonal relationships and community over the individual per se' (p. 1085; see also Blackhall, Murphy, & Frank, 1995; Carrese & Rhodes, 1995).

These inherent differences fuel conflict when specific cultural/ethical decisions need to be made. As an example, Western women predominantly choose to birth in hospitals surrounded by midwives and doctors. For Indigenous Aboriginal women however, hospitals represent bad luck and death. The fear of birthing in a building where people have come to die is contributory to why these women do not readily seek antenatal care, and, as a result, incur higher rates of morbidity and mortality in childbearing as compared to non-indigenous populations.

Johnson and Yates-Bolton (2007) note '1980s research evidence across the western world confirmed paternalistic deception of patients, especially about the nature and severity of their condition as widespread' (p. 367). Today, the transfer of autonomy, authority and decision-making to individuals or patients is widely accepted in North America, while in Europe and other parts of the world both concepts (in response to the effects of multiculturalism) co-exist (Vincent, 1992; Vincent, Parquier, & Preiser, 1989, p. 138).

It would seem cultural and religious diversity may promote conflict when events involving modern medicine do not take an expected or usual course (Ip et al., 1998; Orentlicher, 1992). According to Beauchamp and Childress (1994, p. 85) cultural norms may be unwittingly transgressed in western society by medical professionals who expect to form relationships that are bounded by autonomy, beneficence and justice. Patients are given information on which treatment options or outcomes can be based. However, such an approach to Chinese or other ethnic groups is highly inappropriate and upsetting to the patient and their community. They expect discussion with the family or local community members, after which only information deemed suitable is disclosed to the patient. This difference between eastern and western cultures prompts the question: how do health care professionals – specifically nurses – make decisions and judgements that are ethical when the expectations of individual communities are so varied?

Cultural Diversity in Nursing: it's the Difference that Matters

Nursing has expressed the intention of being a culturally diverse profession. It is therefore assumed nursing behaviours will promote positive patient outcomes by a culturally diverse workforce that provides culturally competent care as the standard and norm. Lowe (1994) points out acceptance of multiculturalism involves the enactment of behaviours by nurses to develop interventions that are culturally appropriate. Lowe and

Archibald (2009) argue culturally specific interventions should be acceptable and mutually agreeable, to both health care providers and patients, and that current health inequities and disparities could be better addressed by a culturally diverse nursing profession.

Cook (2003) confirms contemporary research indicates that without attention to diversity, health care outcomes for patients and the overall quality of health care will diminish, and health disparities will increase. Lowe et al. (2009) note, regardless of the intentions and the efforts made by nursing, advancement in the area of cultural diversity has been slow, sporadic and is overdue.

Nursing as a professional discipline must embrace culturally informed clinical practice that emanates from research and theory and has been tested by nurses within the course of their practice (Lowe & Struthers, 2001). According to Zoucha and Husted (2000), 'the health care provider ought to treat a patient who happens to be from a particular culture as an individual from a particular culture rather than, in effect, to treat the culture through the patient' (p. 326). This philosophy will promote the ability of nurses to use diversity in a competent manner, which in time will become second nature within their clinical practice.

Codes of Ethical Conduct and Patient Advocacy

Before 1970, nurses most often acted in deference to doctors. Indeed, nurses, and most women, were expected to be subordinate to their employers and to anyone else who held a position of power. In the 1980s, however, cultural and social influences caused a significant shift in the attitudes and expectations of health care providers. Western countries such as the United States of America, Canada, the United Kingdom and Australia all adopted codes of ethical conduct for providers of health care.

While the wording is different, the message in the NSW Health Code of Conduct is the same: staff have a duty of care not only to the patients and clients utilising health services, but also to other staff. Staff must ensure as far as practicable, the best interests of patients and clients are maintained in the decision-making process. Health Services have a reciprocal duty of care to staff as well as to patients and clients (New South Wales Department of Health, 2005b, p. 7). By virtue of the establishment of acceptable codes of conduct for health care within western societies, nurses are lawfully and professionally bound to act as advocates for their patients and are compelled to action when a patient's rights or care has been compromised.

Nurses are no longer expected to be subservient to doctors or hospital administrators. Rather, nurses who accept the notion of patient advocacy become champions for their patients, who, because of illness, lack of knowledge or confidence are unable to address issues with their treating

doctors (M. Johnstone, 1994). Nurses, by extension are expected to advocate for patients, yet paradoxically are viewed as disloyal when they question authority or expose behaviour or actions that reflect badly on the organisation (De Maria & Jan, 1994a; Lennane, 1993). According to Ahern and McDonald (2002), very little research exists to explain why some nurses decide to speak out and others do not, although there is considerable explanation available in the literature to suggest moral reasoning may play an important role.

Nurses – Belief Systems and Moral Reasoning

McAlpine, Krisjanson and Poroeh (1997) argue ethical behaviour follows a continuum of cognitive thought that progresses from a narrow, self serving view to a broader, more reflective view. They provide an ethical decision-making tool (ERT) to gain a greater understanding of how nurses apply ethical principles in decision-making. This tool divides nurse responses into three categories:

- Level 1:** Traditional response: nurses acquiesce in obedience to others.
- Level 2:** Traditional/reflective response: nurses, while adhering to traditional boundaries, demonstrate an understanding and acceptance of ethical issues.
- Level 3:** Reflective response: nurses demonstrate patient-focused attitudes within an ethical framework, and a willingness to challenge unethical practices.

Florence Nightingale, the founder of modern nursing, is credited as the profession's first theorist. She presents nursing as a calling rather than a chosen profession for women (1860). Nightingale's inherent belief in the safety and welfare of the patient continues to positively influence patient care today. As in her time, nurses continue to attempt to best represent the interests of the patient; but now, armed with degree qualifications and advanced clinical skills, they have a louder voice with which to speak out. Nevertheless, research confirms (Ahern & McDonald, 2002; Aquino & Thau, 2009; D. Jackson, Clare, & Mannix, 2002) when nurses advocate publicly, the profession retaliates with severe punishment and professional vilification. Theorists such as Ajzen and Fishbein (1980), McGuire and McGuire (1991) and Eagly and Chaiken (1993) contend personal beliefs, organisational constraints and social opinions and experiences impact directly upon a nurse's ability to make sound moral decisions. Weber (1996) argues the type or degree of harm to the nurse and the extent of the consequences directly impact upon the nurse's sense of moral reasoning towards the patient; and the higher the ethical dilemma, the higher the degree of moral reasoning is employed, with a patient's physical harm of paramount concern when compared with, say, economic or psychological harm.

Renowned American nursing theorist Benner (1982) suggests nurses acquire a level of expertise over time, achieved through sound educational practices and repeated exposure to clinical experiences. She argues the acquisition of

knowledge is not achievable without understanding theory. Nursing expertise is gained through example, supervision and mentorship – all of which are necessary.

Grover (1996) concurs with Benner that mastery learning is vital to the acquisition of clinically appropriate skills for nurses, but within the rules of a defined hierarchy within the nursing social group, and notes nurses must emulate the behaviours of their senior colleagues if they are first to be accepted into the social group and then are to be chosen for mentorship. The ethical, hierarchal and role-centred rules and expectations of nursing practice are defined and enforced by the power players in the group. These rules are designed to exemplify the actions 'of a nurse who does the right thing' (K. Smith & Godfrey, 2002, p. 301). The conundrum for the whistleblower nurse is that he/she in good faith, with the applied virtue of being a good nurse, must betray that same nursing hierarchy by public declaration of events in order to protect the patient and uphold the tenet of being a good nurse.

The question 'what is a good nurse?' underpins the act of whistleblowing. To speak out, to speak publicly, the virtue of character is a necessary trait for the nurse who has made the declaration. Adams (2006) in his work on virtue, offers a systematic, comprehensive framework to considering the moral evaluation of character, proposing that virtue is chiefly a matter of being for what is good, and that virtues must be intrinsically excellent and

not just beneficial or useful. The acquisition of virtues, Adams argues, is socially and contextually dependent; this suggests human virtues are replicated and distributed. This theory acknowledges not all humans are of the same character; nor do they possess the same virtues.

For a community to be well functioning, values must be well distributed. Adams (2006) illustrates the distinction between ethical characteristics and ethical actions by pointing out 'the brave are not always the same as the caring' (p. 216). It is clear the appointment of nursing values and ethical actions places whistleblower nurses in an untenable position. The decision to speak out publicly is weighed against the values learned and developed over years of exposure to the norms and mores of the profession of nursing; however, the need to protect and advocate for the patient is paramount, and justifies a nurse's decision to exceed the boundaries of expected professional behaviour.

Patient advocacy is today, an entrenched part of nurse education and practice; an assumed, inherent part of nursing practice (Beyea, 2005; Vaartio et al., 2006). However, as in the acquisition of clinical skills, new nurses need to be nurtured and given the opportunity to learn how, and more importantly why, they must advocate for their patients (Benner, 1982; Foley, Minick, & Kee, 2002). The concept of advocacy is not a recent practice development for the profession of nursing. Florence Nightingale seemed quite clear on her role as a patient advocate. During the Crimean War, 'her

rigid approach to managing the care and environment of patients certainly implied an underlying fervour, the likes of patient advocacy' (A. Smith, 2004, p. 1).

The sharing of nursing stories parallels Benner's (1991) view that advocacy, like all nursing skills, is learned from participation in nursing community, where the action is good, and is part of everyday life as a nurse. Foley, Minick and Ke's (2002) study of how nurses develop advocating practices, makes three findings. First, establishing advocacy in nurses' practice is 'more deeply rooted in who they were and how they were raised than in a learning process' (p. 183). Second, nurses learn advocacy by watching and talking to other nurses. Third, nurses learn to advocate as they gain confidence not only as clinicians but as part of the social group, where direct learning and the behaviours of mentors can be emulated.

The outcome of the Foley, Minick and Ke's (2002) study shows nurses learn advocacy from family and community experiences. Mallick (1997) asserts 'there is a need for a more systematic analysis of nurses' activities that could be labelled as advocacy' (p. 134). For whistleblower nurses, the urge to advocate for patients is drawn from inherent personal beliefs, professional experience and the innate need to protect the patient. As these skills, through learning and observation are acquired over time, explains why it is rarely a junior nurse who speaks out publicly. Rather, as confirmed in this research, nurses who advocate for patients tend to be highly experienced.

Each of the participants of this study had more than three decades of nursing experience.

'Good' nursing care is that which is offered by a 'good nurse' according to B. Kelly (1993); and 'ethical nursing is what happens when a good nurse does the right thing' (p. 27). The practice of nursing is by nature a moral endeavour (K. Smith & Godfrey, 2002). Inquiry into the concept of 'good in virtue or existing contexts' (B. Kelly, 1993, p. 303), began with Florence Nightingale who frequently stated, 'You cannot be a good nurse without being a good woman' (Baly, 1986, p. 25). Davis (1990) concurs with Nightingale in that the ideals of nursing are not simply applied to nursing roles and obligations, but also to 'virtues, not only of conduct, but of character' (p. 686). Sarvimaki (1995) stated the ethics of caring, personal and situational moral knowledge impacts upon virtue and care in nursing practice. In D. Robertson's (1996) study, a nurse participant said, 'Many qualities needed to become a good nurse have more to do with character and morality [as opposed to those needed to become a good doctor]' (p. 295). For whistleblower nurses in Australia, the cultural tenet 'do the right thing' creates extreme conflict: do the right thing and advocate for the patient, or do the right thing and remain loyal to and supportive of your employer and nursing group.

Research into the lived experiences of nurse whistleblowers is well documented (Ahern & McDonald, 2002; P. Jackson et al., 2010; Shallcross,

Ramsay, & Barker, 2010). Grant, (2002) Bolsin, Faunce and Oakley (2005) and Kline (2006) describe whistleblowing as Kantian because the act is related to duty and utilitarianism. Gregor (1996) confirmed this allusion is to Kant's 1793 theory that instructs people to act harmoniously within accepted rules. Truth telling is at the heart of this theory and is clearly applicable to nursing; for a nurse is expected to truthfully carry out his/her duty in a professional and harmonious manner. This research rejects the idea of confining behaviour to conform to group politics and does not support the Kantian theory as being applicable to the act of whistleblowing by nurses. The argument against the appropriateness of this theory for nurses who blow the whistle is that professional conduct when exercised as a public declaration of a perceived truth is invariably disharmonious for all concerned. This is clearly the situation for nurses who publicly advocate for their patients.

Why do some nurses speak out publicly while others, regardless of the circumstances, never speak outside of the walls of their organisation? Ahern and McDonald (2002) conducted an inquiry to ascertain if the individual belief systems of nurses influenced some who encountered ethical dilemmas when caring for patients to become whistleblowers while others did not. The study was conducted with the cooperation of the Western Australian Nurses Board, and consisted of surveying a sample of five hundred registered nurses randomly selected by computer. A twenty percent response rate was

achieved. The study covered relevant patient advocacy statements and included whistleblowing experiences. Included were statements from current ethical codes of conduct and questions related to traditional nursing attitudes or related specifically to a whistleblowing experience. Of interest, three quarters of the respondents identified themselves as whistleblowers, which is a higher representation in the workplace than was expected. The researchers discovered their hypothesis was confirmed: whistleblowers and non-whistleblowers tended to operate from different belief systems that affected their decision to follow the professional imperative that nurses will advocate for their patients, to the extent of speaking publicly.

Caring – the Nurse’s Mantra

The concept of caring as a defining characteristic of nursing has long been a source of considerable debate among nurse theorists (Paley, 2002a). This debate has raised the question: does the paradigm of caring as described by Benner (2000) and Barnum (1998) constitute ethical behaviour for nurses? An ethic of care is, according to Tarlier (2004), a superficial way of attempting to describe the complex integration of personal and public moral knowledge which is the basis of nurse–patient relationships. Conversely, Warnock (1998, p. 2) describes nursing ethics as a form of public morality resulting from the nurses’ intrinsic, individual sense of morality that defines the role and obligations arising out of and attributed to their professional role. Paley (2002b) acknowledges caring as fundamental and conflicting to

the ethical basis of nursing, while acknowledging the pervasiveness of the culture of care within the profession (Bowden, 2000).

The concept of caring is highly desirable in a professional nurse. It seems the act of caring is frequently associated with the stereotypical feminine role of performing women's work, while tending the sick is an ethical concept considered central and inherent to the profession of nursing (Barnum, 1998; Bowden, 2000; S. Lewis, 2003; Liaschenko, 1993).

Patient Advocacy

The Oxford English Dictionary (1989) defines a person who advocates as one 'who is called in as a pleader or a caller for justice or mercy'. An advocate is described as 'one who is summoned or called to another, especially one called to aid one's cause in a court of justice' (p. 194). According to MacDonald (2006), the clearest meaning of advocacy in a nursing context is Gadow's (1990) definition: 'Advocacy not only safeguards but contributes positively to the exercise of self-determination. It is the effort to help patients become clear about what they want in a situation, to assist them in discerning and clarifying their values and examining available options in light of those values' (p. 53).

Patient advocacy according to Grace (2001) denotes an ideal of practice which involves providing patients with the information they need to make informed decisions, support for their decisions while safeguarding their

dignity, safety and interests (Ahern & McDonald, 2002). The profession of nursing, they argue (McDonald & Ahern, 1999), 'places great emphasis on the ability of nurses to make sound judgements when they identify situations that endanger patient safety or jeopardise patient rights' (p. 5). In recognition of this fact, developed countries around the world have embraced codes of professional conduct for nurses and health care providers. Nurses are mandated to protect patients against unethical or unlawful practices. The principle of beneficence is an intrinsic part of patient advocacy. Macciocchi, French and Bush (2009) said beneficence is more than simply doing good in a generic sense: rather, nurses via the principle of beneficence are obligated to help and further the important and legitimate interests of others.

In nursing, the application of advocacy is conflicting, for the nurse must consider whether advocating for a patient in a certain way may compromise the health of this individual or of other patients (Grace, 2001). Advocacy in nursing is based on a broad understanding of responsibility and accountability, and as such, Grace argues, 'nurses cannot reasonably claim they failed to anticipate the negative consequences of their judgements and actions on others' (p. 155). It is this sentiment that greatly increases the potential for conflict in nurses who advocate for their patients. What is interpreted as advocacy by one nurse may be interpreted differently by another; and where does a nurse's professional responsibility begin and

end? Does the nurse who advocates for a patient's welfare remain a legitimate advocate whatever the level of escalation of concern? Or is the nurse labelled a whistleblower?

Perhaps the greatest challenge to nurses who advocate relates to the accuracy of representation of the patient's preferences and wishes (Beyea, 2005). Rodney et al. (2002) state 'nurses work in a shifting moral context that vacillates in between their own values and those of their employing organisation, in between their own values and those of others and in between competing values and interests' (p. 80). Moreover, there may be barriers to advocacy. In Millette's (1993) study of client advocacy, two hundred and twelve nurses were interviewed and three advocacy models were defined. First was the 'bureaucratic model', in which the needs of the organisation outweighed the needs of the individual patient or nurse. Second was the 'physician model', where the needs of the doctor were paramount; third was the 'client model', whereby the needs of the client/patient were of primary importance (p. 607). Two thirds of the nurses surveyed indicated a preference for the client/patient model; however when Millette asked the interviewees to respond to a particular moral dilemma to which all three models could be applied, 81% of those nurses who had selected the client/patient model suggested their preferred model was the worst choice. Millette (1993) surmises, 'perhaps much of the attention to this role (client/patient advocate) has been to its conceptual nature, with less

concern addressed to the implications for practice' (p. 616), and adds the nature of the relationships between the nurse and other members of the health care team may influence the extent to which nurses will advocate for their patients.

Rodney et al.'s (2002) study shows nurses manoeuvre between competing values and interests and barriers. The imposed values of peers can and do present overwhelming obstacles for nurses who try to advocate for their patients. Rodney et al. determined nurses' ethical decision-making is achieved by a process of 'navigating towards a moral horizon' on a course 'often not smooth or certain' (p. 80).

Organisational Behaviour and its Effect upon Nurses

According to Dellasega (2009), nursing work is driven by managerial imperatives. Hutchinson, Vickers, D. Jackson and Wilkes (2005) argue intense scrutiny by managers of nursing activities compounds nurses' stress and promotes an environment in which bullying will prosper.

In the 1990s, Australia and the rest of the developed world underwent a perceivable shift in the major political and social indicators such as health, welfare and education (Lange & Cheek, 1997). The Australian experience 'saw a divergence from the social democracy model to a more right wing approach that embraced the doctrines of free market economies' (Lange & Cheek, 1997, p. 5). Issues of privatisation, deregulation, the user-pays

system and the outsourcing of services, outcomes and customers became the new language of policy texts. Health care was not unaffected by these trends. The term 'customer' instead of 'patient', say Lange and Cheek, implies a buying and selling relationship. Rationalisation of dwindling health resources and the failure of governments to recognise nursing within the wider social policy context ultimately impacts upon the delivery of nursing care (Parkes, 1994). Salin (2003) confirms Einarsen, Matthiesen and Skogstad's (1998) perception that increased levels of conflict and bullying occur among nurses in 'organisations that are experiencing restructuring, downsizing or other crises, where job security is low or where there is internal competition in the facility' (p. 1120). Paterson, McComish and Aitken (1997) note workers may face extreme pressure or conflict from managers who demand results and care little for the methods used to meet organisational targets. The conflicting demands of organisations with continually shifting goal posts positions nurses as ready targets for bullying in the workplace.

Maternalism

The maternalistic concept of motherhood is, according to Cloyes (2002), associated with woman, female, feminine, and feminist and is significant and related to other associations of care defined by class, race, ethnicity, nationalism and profession. Christensen and Hewitt-Taylor (2006) note maternalistic behaviours are commonly exhibited by nurses under the

premise of caring for their patients. Tarlier (2004) warns caution is required within nurse–patient relationships when striving to balance maternalism with patient advocacy. Moore (2000) controversially identifies maternalism not only with the idea that should nurses do good, it is with the belief that that they are in the best position to know what is good for patients.

Since the 1960s the concept of caring and nurturing of patients has been superseded by the principle of autonomous nursing practice, which is grounded in science, theory and empirically tested practice procedures. However, the literature suggests it is still the responsibility of the nurse to interpret the patient's requests and wishes accurately (Beyea, 2005). Beyea suggests it is when the nurse, independent of patient requests, projects what she/he believes to be in the best interest of the patient that the line is crossed from advocacy to inappropriate, maternalistic or paternalistic behaviour.

Definition of Whistleblowing

There is debate in the literature as to the most accurate definition of the term whistleblowing. Fong (1998) considers whistleblowing to have occurred 'when an employee reveals information that proves a violation of law, errant mismanagement practices, waste of funds, abuse of authority or a substantial and specific danger to public health and safety' (p. 9). The definition of whistleblowing by Dempster (1997) does not rely on proof;

rather, whistleblowing involves making known the issue or event in a public forum or another form of public record.

This research accepts the definition of whistleblowing by Dawson (2000), which is based on the work of Jubb (1999) and Chiasson, Johnson and Byington (1995): whistleblowing is 'the deliberate, voluntary disclosure of individual or organisational malpractice by a person who has or who has had privileged access to data, events or information about an actual, suspected or anticipated wrongdoing within or by an organisation that is within its ability to control' (p. 25). The disclosure may be internal or external, and may not necessarily be a matter of public record.

Characteristics of a Whistleblower

Dawson (2000) wonders whether there are specific personality types or individual traits that predispose a person to whistleblowing. Descriptors used to define potential whistleblowers according to Seligman (1999) range from disgruntled employees, to self interested malcontents, to determined high achievers with universalistic values and high self esteem (Jos, Tompkins, & Hays, 1989). Ahern and McDonald (2002) define whistleblowers as those who:

support the belief that nurses were primarily responsible to the patient and should protect the patient from incompetent or unethical people. Whereas, non whistleblowers support the belief that nurses are

obligated to follow the physician's order at all times and that nurses are equally responsible to the patient, the physician and the employer.
(p. 303)

According to Dawson (2000) neither gender, marital status, nor educational attainment, nor religiosity, nor number of promotions, nor supervisory status are of help in determining those who are predisposed to whistleblowing; in fact, there are no identifying traits to support the concept of a whistleblowing personality. Rothschild and Miethe (1999) disagree, arguing 'individuals who possess universalistic values were more likely to speak out and blow the whistle if internal disclosure did not address the issue. The paradox for organisations that seek to recruit employees with ethical work practices, is that these employees are likely in return to expect their employers to behave ethically and practice what they preach' (p. 109).

Internal Disclosure

Jubb (1999) describes internal disclosure of information as qualitatively distinct from the act of whistleblowing. Internal disclosure relates to the legitimate process of reporting through rightful organisational, hierarchical processes. While internal disclosure is considered to be appropriate for employee reporting strategies, inaction by managers is most commonly cited as the catalyst for whistleblowers to escalate their claims to outside agencies (Dawson, 2000).

In one hundred percent of the cases studied by Lennane (1993) and in the majority of cases described in the studies by De Maria and Jan (1994b) and Rothschild and Miethe (1999), employees initially reported internally, through legitimate organisational channels. The respondents in these studies all ascribed the escalation of their allegations to external agencies to frustration, and a perceived failure of internal disclosure as the catalyst for change. Paradoxically, none of the respondents of these studies ever intended or believed they would have a need to escalate their concerns; the majority believed internal disclosure would be adequate to see the issues addressed, and believed their employing organisations would support them in their efforts to address or eradicate the wrongdoing.

External Disclosure

The 1992 quantitative survey by Lennane (1993) involved thirty-five respondents from a range of occupations who had exposed corruption or safety issues that affected the public. All of the participants had suffered adverse consequences as a direct result of speaking out. All respondents had lodged their complaints internally through what was perceived to be the proper organisational channels. Hunt and Shailer (1995) confirm health care professionals too generally try to instigate organisational awareness and response to their reported concerns before speaking out publicly.

Jos (1991) points out external disclosure is not a method that will influence organisational behaviour because 'this type of behaviour will generate a

culture of minimal compliance when externally enforced, rather than that of adoption of high standards as a matter of choice' (p. 116). Nevertheless, as Wilmot (2000) argues, whistleblowers may, because of principles such as truth telling, openness and integrity, perceive they have no choice other than to speak outside of the organisation. Whistleblowers who expose corruption and malpractice may speak out for the greater public good, but they do so at considerable personal risk (Lennane, 2000).

The Role of the Media in Whistleblowing

'Social policy makes neither news, nor history unless there is some chaos,' said political and social commentator Polly Toynbee (1999, p. 16). Franklin (1999) agrees, saying the media has a tendency to 'report social policy issues in highly critical if not apoplectic terms' (p. 1). The media enjoys significant influence and plays a pivotal role in the shaping of public perceptions of and opinions about political and social issues (J. Wilson & Wilson, 2001; Wimmer & Dominick, 1991). What we believe is often based not on first-hand experience but on the way events are shaped and reported in the popular media. The infiltration of the media into our thoughts, feelings and perceptions is termed 'cultivation theory' by Gerbner, Gross, Morgan and Signorielli (1980, p. 11); it is explained by Infante, Rancer and Womack (1997) as the way in which 'popular media, such as television, has the power to influence our view of the world ... it is primarily responsible for our perceptions of day-to-day norms and reality' (p. 383).

Television provides a constant flow of information ranging from images of war to the portrayal of the lives of favourite characters in popular shows. Research confirms our attachment to these characters promotes a type of familial association and bonding, comparable to that of real family members. Severin and Tankard (1997) assert people who watch extensive amounts of television are highly likely to perceive the world as it is presented on the television screen, although Dearling and Rodgers (1996) argue the potential of the mass media to influence our thinking is exaggerated. They contend agenda-setting theory places less emphasis on the effect the media has on our conscious thoughts and more on what issues are being discussed in the media. Bernard Cohen (1963), an early proponent of agenda setting theory, once famously said, 'the press may not be successful much of the time in telling people what to think, but it is stunningly successful in telling its readers what to think about' (p. 13).

The power and influence of aggressive journalistic reporting in the Australian media is well known (Balsom, 1999). It drives the sales of newspapers and influences television ratings. Today's media is highly political, enormously influential and inherently biased. B. Fields' (2006, p. 6) survey of literature regarding the media identifies eight categories of bias in newspapers and other media (M. Lee & Solomon, 1990; Media Awareness Network, 2005):

- a.** Bias through selection and omission. What details, events or perspectives are showcased?

- b.** Bias through placement. The importance of the story is closely aligned with the placement on or near page one of the newspaper.
- c.** Bias by headline. The choice of words depicting the story influences its significance.
- d.** Bias by photos, captions and camera angles. The emotive nature of a situation can be used to promote the agenda of the media.
- e.** Bias through the use of names and titles. Definition is offered to the use of titles and the labels used to describe them.
- f.** Bias through statistics and crowd count. Selective or inaccurate representation of the words chosen to depict crowd size.
- g.** Bias by source control. The deliberate use of positive or negative words to describe a person or situation.

Whistleblowers rarely speak publicly as a first approach to bringing the attention of the organisation to their concerns. It is usually after all internal avenues have been exhausted that stories become public. Rothschild and Miethe (1999) find 'employees go to external authorities once they believe internal channels are closed to them, the organisation is not moral and senior management is inert or complicit in wrong doing' (p. 124). This opens the whistleblower to public scrutiny and critique: as Dempster (2002), says, 'the media will actively exploit the phenomenon of whistleblowing to the full' (p. 2). There is little regard for the person who has made the decision to go public; presentation of the case to catch public interest is paramount. As Whitton (2000) explains, 'the role of the media is to interest and amuse

customers, to seek the truth and to serve the community by exposing wrongdoers, particularly those who subvert democracy by corruption' (p. 1).

The media are commercial enterprises. Their challenge is to keep their readers, viewers and listeners interested, therefore influencing public opinion. James Cameron (cited in Dempster, 2002, p. 3), a London journalist coined the term 'the Cameron effect' – a theory about the formation of public opinion. Cameron states, public opinion can be formed in a way similar to a physics experiment, where bombardment of particles (in the case of the media, persuasive argument) continues until critical mass (or opinion) is reached.

Whistleblowers accept great personal and professional risk when they move past the last step of speaking up to the 'irretrievable step' of public disclosure, which is often a 'last ditch stand driven by desperation' (Jubb, 1999, p. 92). Unfortunately, the purpose of the media to entertain with 'glamour scandals, the headline grabbers' (Dawson, 2000, p. 3) is at cross purposes with that of employees who feel obliged to reveal that their employers have failed to address their concerns about serious issues.

Malicious Whistleblowing – where there is Smoke there is Fire

Dawson (2000) states

whistleblowing cannot take place in a vacuum: even in instances of malicious whistleblowing, there must be a possibility that some form of

recognisable malpractice has occurred in order to make a case for investigation, regardless of whether the allegation is subsequently found to be incorrect. (p. 12)

Dawson (2000) argues any public disclosure, even with a perceived malicious motive, should be investigated, as it is important to understand the motive of the person who has made the public disclosure.

Eaton and Akers (2007) recognising the gravity of the consequences of speaking out publicly, assert organisations must exercise good governance procedures and create an environment where a potential whistleblower can report issues that are of concern before there is a perceived need to speak outside of the organisation. They too believe it is imperative all declarations by whistleblowers be taken seriously, with investigation, evaluation and discipline where indicated.

In Australia, according to Zipparo (1999), legislation provides severe penalties for whistleblowers who make vexatious or misleading claims. It is therefore unlikely the motivation for whistleblowers is mischief making, dissatisfaction or malice. Organisations confronted by employees who are prepared to voice their concerns, run the risk of negative consequences from public declarations.

The Australian 'Do- the- right- thing' Ethic

Employees who speak out are not necessarily out-of-the-ordinary workers who are gifted with insight or experience of organisational practices; rather they are most likely workers who perceive a wrong which is not addressed by the organisation. The literature confirms the decision to speak out is frequently made by employees who are ethically minded and who, based on a personal philosophy of doing the right thing, make a decision to voice concern about an event or practice that is perceived to be illegal, unlawful or immoral (McAlpine et al., 1997). Co-workers may be aware of the event or practice, but choose to remain quiet for fear of the consequences of speaking out (Ahern & McDonald, 2002).

Whistleblowers, according to De Maria and Jan (1997), can reasonably expect to be marginalised by co-workers who, in order to protect their own careers, distance themselves by alignment and demonstration of solidarity with organisational management. However, as De Maria and Jan (1997) discover, co-workers have a public and a private face for their interactions with whistleblowers. In public, co-workers may be openly critical of those who speak out, while covertly they applaud the whistleblower for having the courage to publicly voice their concerns; they may congratulate the whistleblower for showing integrity and offer clandestine encouragement. However, the whistleblower cannot rely on co-workers for public support as often the risks to those who keep company with whistleblowers are too great

and many do not want to be penalised by becoming involved (Ahern & McDonald, 2002). This research confirms nurses 'run with the wolves but hunt with the hounds' when dealing with other nurses who have been labelled whistleblowers.

You Don't 'Dob' in a Mate

According to Catanzariti (1998) the Australian term 'you don't dob in a mate' is a colloquial term for a cultural norm that rules workers do not speak out to management about each other – whatever the reason. The ethos of mateship is to promote camaraderie and loyalty in the ranks, but may also be the very reason some employees choose to ignore events or practices and opt to tread a safe path in silence. Fong (1998, p. 9) confirms reprisals against whistleblowers are fuelled by an Australian cultural aversion to 'dobbers'; blowing the whistle is rewarded not with praise but with reprisals. P. Jackson (1999, p. 44) notes that labels such as 'rat', 'squealer', or 'dobber' are applied to discourage whistleblowers from disclosing adverse events, outcomes or practices.

Bullying and Harassment: 'Circle the Wagons then Shoot the Messenger'

Employees who encounter issues such as corruption or fraud are frequently faced with difficult choices. Joel (1997) finds this is particularly true for nurses who risk moral compromise, a clash between their duty to their patients and the need to avoid organisational conflict in order to stay

employed. To make the decision to report an issue, either internally or to an outside agency, may prompt criticism or harassment from co-workers or management. To do nothing may be morally and socially unacceptable to the employee.

There is a plethora of evidence in the literature which confirms bullying is widespread in nursing (Deans, 2004; Garland, 1999; C. Holmes, 2006; Hutchinson et al., 2005; Lennane, 1993). D. Jackson, Clare and Mannix (2002) assert 'in a climate of a declining nursing workforce where violence and hostility are a part of the day to day lives of most nurses, it is timely to name violence as a major factor in the negative recruitment and retention of registered nurses in the health system' (p. 13). They also acknowledge that violence is increasingly common in many societies, with violence towards nurses an alarming, significant occupational hazard.

Not all violence is physical assault, verbal abuse or sexual harassment (J. Madison & Minichiello, 2000; Taylor, White, & Muncer, 1999). McMillian (1995) identifies nurses at all levels, from all specialties, in both public and private sectors, as susceptible to violence in the form of bullying. Bullying is not limited to a defined set of behaviours, as Paterson et al. (1997) indicate: it can vary from overt aggression to covert social exclusion. Episodes of bullying may involve single individuals or a faction colluding against an individual or group. M. Lewis (2006) states:

bullying within nursing is primarily intraprofessional (i.e. between nurse and nurse) ... nurses themselves are open to conflict and cannot be regarded as a homogenous professional group, rather as a profession, they strive in conflict for liberation from the force that disempowers the profession – the nurses themselves. (p. 53)

Rhodes and Strain (2004) confirm historical influences affect the way in which the health care workforce is socialised, and ultimately contribute to organisational vulnerability. M. Lewis (2006) agrees: 'bullying activities in nursing are essentially learned behaviours within the workplace, rather than any predominately psychological deficit within individual perpetrators and targets' (p. 53). Grover (1996) concurs, adding that nurses achieve their place in the nursing hierarchy 'through a process of socialisation', whereby they must learn the social rules of the nursing workplace. In order to be accepted within the group, the lessons or rites of passage must be survived. It is from such processes that the behaviours of the wider work group are adopted, learned, emulated and enforced (p. 37).

Bullying, Harassment and its Effect upon Organisational Morale

The consequences endured by whistleblowers are well represented in this thesis and the literature. The whistleblower is bullied, harassed and marginalised. This is a powerful deterrent to others who would also tread this path, for the seed of fear undermines valued trust relationships (Milliken, Morrison, & Hewlin, 2003) and has a major impact on morale (Day, Minichiello, & Madison, 2006). The erosion of social and group

relationships suggests solidarity of nurses is dependent on morale (Daum, 1993).

The research confirms the way organisations react to nurses who raise concerns impacts directly on other employees and their willingness to share information that may be perceived to be negative or threatening to the organisation (K. Roberts & O'Reilly, 1974). Milliken et al. (2003) stated the fear associated with the appointment of a negative label such as being a 'trouble maker' or a 'complainer' (p. 207) influences the decision to speak up or stay silent. The appointment of labels has significant consequences for the individual. Labels are communicated to others with the intention of legitimising the label as an accurate depiction of the targeted person (Milliken et al., 2003). Ashforth and Humphrey (1995) confirm labelling alters interpersonal relationships, affects social identity and creates self fulfilling prophecies which seemingly validate the label.

The act of whistleblowing impacts negatively on morale because of the inherent hierarchy of fear associated with the exposure of often highly sensitive information, public reaction, and the very real risk the whistleblower may reoffend and speak out again (Leymann, 1990; Rothschild & Miethe, 1999). Day et al. (2006) state morale is affected by 'intrinsic factors such as professional worth, respect, opportunity, skill development and work group relationships which to some degree are able to be controlled by the individual'. These factors '... impact upon nurses'

concept of personal or professional standing within the group. Extrinsic factors such as 'organisational structures, operational issues, leadership traits/management styles and communication, are largely beyond the control of individual nurses or work groups'. It was stated 'nurses have control over intrinsic factors that impact upon their level of morale' (2006, p. 518). To choose to maintain silence over matters of concern is not only a self protectionist strategy it is a means of guarding the appointed position in the nursing hierarchy while preserving morale within the nursing social group (pp. 517-518).

Nurses and health care professionals are often fearful of whistleblowers because of the dread of perceived association. Whistleblowers are worrisome to organisations, for public exposure is not only damaging, but impacts upon the perceived competence of the managers and supervisors, and upon the level of faith the public affords the organisation. Rosen and Tesser conducted a study on one possible reason why people are reluctant to communicate to their bosses and supervisors. They identified the 'mum effect' as a phenomenon whereby individuals are afraid to convey negative information to supervisors for fear of 'the discomfort associated with being the conveyor of bad news' (1970, p. 255). The fear of becoming less popular or less likely to succeed forces some people to maintain silence. For this reason, whistleblowers experience acts of detachment and separation from colleagues who previously included them. The whistleblower also

experiences plummeting job satisfaction and morale, for marginalised workers are not encouraged to actively participate in the workplace. The whistleblower is not only reduced to a label, but also is appointed a position of exclusion and shame within the nursing hierarchy. Whistleblowing negatively impacts on the morale of the organisation, the people who work within it, and the whistleblower involved.

Workplace Mobbing

Psychologist Heinz Leymann (1990) in a 1984 Swedish study of workplace violence coined the term 'mobbing' to describe a form of organisational pathology whereby individual workers are set upon and targeted in an ongoing ritual of humiliation, degradation, marginalisation and exclusion. Ozturk, Sokmen, Ylmaz and Cilingir (2008) define mobbing as 'emotional assaults within workplaces ... associated with bullying and stalking' (p. 436); the express aim of mobbing is to decrease work performance and coping skills, with the resignation of the bullied worker the ultimate goal. Leymann (2006) describes mobbing as 'a progressive process that increasingly causes more pain, starts insidiously, shows inevitable progression and becomes irreversible in the end' (p. 10).

According to Rosen et al. mobbing targets are:

typically highly principled individuals who trust in the decency and goodness of the organisation ... who strongly identify with the work

that they do ... who love their work ... and believe in organisational goals and care about the organisation's reputation. (2007, pp. 4-5)

It seems the inherent characteristics attributable to the personal, professional and ethical attitudes of nurses who speak out publicly render them vulnerable to co-workers who employ mobbing tactics.

Leymann's (2006) study involved five hundred and five nurses, sixty-four percent working in public hospitals and thirty-six percent in private hospitals. First degree mobbing was associated with crying, sleep disorders and lack of concentration. Individuals who incurred second degree mobbing, in addition to these symptoms, experienced high blood pressure, gastrointestinal problems and eating disorders, and admitted to using alcohol, cigarettes or drugs. Nurses who experienced third degree mobbing, in addition to all of the above, expressed fear of the workplace, restlessness at work, chest pain, heart palpitations and a tendency to become reactive to the point of violence towards other staff members. A staggering ten percent of the respondents of the Leymann study considered suicide. An important finding of this study was that, when nurses are victims of mobbing, their sadness and distress causes a negative spill-over effect on the bullied nurse's families (Leymann, 1990).

Leymann (2006) describes five stages of mobbing:

- 1.** There is conflict at this stage, which is not defined but may turn into mobbing.
- 2.** Aggressive behaviour and psychological attacks indicate mobbing has been triggered.
- 3.** Management understands and may become involved in the mobbing tactics.
- 4.** Mobbing victims are stigmatised as being difficult, unethical or emotionally ill. The lack of understanding by administration and/or other professionals then accelerates the process. At the end, victims are either fired or forced to resign, or may simply give up and leave the organisation.
- 5.** The victims are expelled, which may trigger post-traumatic stress disorder. The victims ultimately experience emotional stress followed by psychosomatic disorders, which may become severe (p. 184).

Rosen, Katz and Morahan (2007) cited Leymann's (1996, 2006) research and concurred with these findings in their study of the phenomena of bullying and harassment within the academic and health care setting. Behaviours such as increasing marginalisation or isolation, being the object of gossip, being delegated meaningless tasks, being subjected to public criticism, humiliation or ridicule are described as typical of workplace bullying. It is acknowledged that mobbing activities occur in places of work almost everywhere in the world. Ozturk, Sokmen, Ylmaz, and Cilingir (2008) estimate mobbing behaviours are three times more prevalent in nursing

than any other profession, and note that there are very few studies of this specific instance of bullying.

As nursing has a predominantly female workforce, to understand why nurses bully one another, it is important to gain insight into bullying, aggressive behaviours in women. It is widely acknowledged that males express aggression through acts of 'physical violence, whereas females employ character defamation, humiliation, betrayal of trust and exclusionary practices' (Rys & Bear, 1997, p. 90), all of which are characteristic of relational aggression.

Relational Aggression

Dellasega (2009) describes relational aggression as a type of bullying typified by psychological rather than physical abuse. Wood (2002) argues while males are socialised to domineer and exhibit physical and verbal aggression, females learn to hide their intent to harm others with acts of subterfuge and quiet malice (Lagerspetz, Bjorkqvist, & Peltonen, 1988). Pellegrini and Long (2002) identified a link between this type of behaviour and childhood bullying, sexual and workplace harassment and elder and child abuse. This behaviour is termed relational aggression, which Raskauskas and Stoltz (2004) define as 'a type of bullying which refers to the use of psychological and social behaviours rather than physical violence to cause harm' (p. 215). Relational aggression, rather than the better known terms lateral or horizontal violence, is the more apt description of violence

that occurs between nurses in the workplace (Dellasega, 2009, p. 54). Leiper (2005) argued these terms are too limiting as lateral and horizontal violence refers to aggression between persons on the same hierarchical level, whereas relational aggression can occur between people at different levels. Dellasega (2009) states it is worthy of note that 'relational aggression can also extend beyond normal working hours and can occur in person or in cyberspace' (p. 58). The literature confirms relational aggression exerted by female nurses can underpin bullying nurse-to-nurse behaviours which may progress to the five stages of mobbing described by Leymann (2006).

The Bully Girls

The predomination of females in the profession of nursing is the reason for the use of the pronouns 'she' and 'her' in the work of Dellasega; therefore, an assumption is made that the people involved in bullying within the profession of nursing are predominantly female. Dellasega (2009) finds there are triggers in the form of certain situations or events that predispose a nurse to being bullied: 'being a new graduate or a new hire; receiving a promotion or honour that others feel is undeserved; having difficulty working well with others; receiving special attention from physicians and experiencing severe understaffing' (p. 54). Dellagesa (2009) defines six categories of nurse bullies based on descriptions nurses offered in their stories of bullying in the workplace:

The super nurse

Has 'been there and done that' and is more competent than her co-workers and she will make sure they know it.

The resentful nurse

Holds grudges and is capable of inciting co-workers to support her by ganging up on nominated targets.

The put-downs, gossip and rumours nurse

Uses put downs, gossip and rumours to bully other nurses.

The backstabbing nurse

Offers the hand of friendship and gains confidences that she willingly betrays.

The green-with-envy nurse:

Covets what she does not have and expresses her bitterness through uncooperative or disruptive behaviours.

The cliquish nurse

Uses exclusion as a form of aggression by creation of groups that are allowed inside her clique and those that are deliberately excluded (pp. 54-55).

The Direct and Indirect Consequence of Truth Telling

A review of the literature reveals the physiological, emotional and social effects commonly experienced by nurses who have encountered workplace bullying. Leymann (1996) and Hansen et al. (2006) agree the effects of bullying on individuals are not easily quantifiable as each individual reacts differently. The literature confirms the consequences experienced by nurses who speak out are far-reaching, and are not limited directly to the

whistleblower. Lennane (1993) records reactions to whistleblowers that are intimidating and terrorising, ranging from the slaughter of domestic pets to stalking and death threats.

Direct consequences, include psychological terror (Leymann, 1996), bullying (Hockley, 2000), harassment (J. Madison & Minichiello, 2000), workplace trauma (L. Wilson, 1991) and victimisation (Gini, 2008). Leymann (1996), Einarsen (2000) and Cowie, Naylor, Rivers, Smith, and Pereria (2002) identify deliberate isolation and marginalisation along with deprivation of organisational resources as examples of indirect retaliatory consequences for nurses who speak out.

Goals to Decrease Mobbing

Ozturk et al. (2008) argue the implementation of 'good business practices such as determination of organisational views and values ... will establish how employees are treated' (p. 440). They consider it imperative that workplaces comply with organisational structures and values, and policies relating to standards of behaviour and ethical conduct exist and are known throughout the organisation. They also consider it important to ensure clear processes are in place to deal with episodes of mobbing, with the delegation of a person or committee to create solutions early in the reporting process. All staff should be offered training in identifying and averting workplace bullying and there should ideally be an employee assistance program for staff who believe they are being bullied.

The NSW Department of Health Code of Conduct states:

violence is defined as any incident in which an individual is abused, threatened or assaulted and includes verbal, physical or psychological abuse, threats or other intimidating behaviours, intentional physical attacks, aggravated assault, threats with an offensive weapon, sexual harassment and sexual assault. (2005b, p. 38)

Dellasega (2009, p. 55) advocates 'a plan for change' that will be pivotal in reducing the incidence of nurse bullying by employing administrators who are willing to decentralise authority and create more democratic and less hierarchical workplaces (p. 55). Ramos (2006) acknowledges nurse-on-nurse bullying is a well accepted problem that is largely unaddressed by administrators, and claims there is an 'apparent culture of disrespect among health care providers' (p. 36). Hutchinson et al. (2005) note that in an attempt to promote a change within nursing culture, Australia has adopted a zero tolerance to violence policy, aimed at raising awareness of and prevention of bullying incidents in the workplace. The responsibility for implementing this policy falls upon nurse educators, who are expected to ensure all staff, including students, receive education and formal preparation to reduce incidences of bullying.

Plan for Reduction of Nurse Bullying

Dellasega (2009) stated organisations must include reduction of bullying by:

1. Distribution by the nurse manager of an anonymous survey to nurses to quantify the emotional climate of each area.
2. Achieve a goal whereby nurses understand and speak a common language about relational aggression.
3. Consider and implement issue-specific strategies within each individual area, by implementing an accepted, assertive communication process which all staff are required to endorse annually; and adopting an agreed conflict resolution process.

There are a number of strategies cited in the literature to address the issue of workplace mobbing (Sheehan, 2004). Shallcross (2003) contends legislative change to the Sex Discrimination and Health and Safety legislation would enable legal redress, to ensure mobbing behaviours do not occur. Sheehan (2004) believes legislators have been slow to react to the call for change, and points out, in any case there is no guarantee that legislation will make workers change their attitudes or behaviour to reduce workplace mobbing. Westhues (2004) argues instead, organisations as a whole need to be aware of the issues related to workplace mobbing and replace punitive, reactive responses to mobbing (Sheehan, 2004) with preventative, educative strategies.

Mobbing Behaviour – a Disincentive to Speaking out Publicly

It was noted by Wilmot (2000) 'by harassing, dismissing or even prosecuting whistleblowers, a set of harms is weighed against the benefits of whistleblowing, which in practice, makes it less likely (as no doubt is the intention)' (p. 1056). Wu (2000) identifies fear of reprisals, individual repercussions and blame as disincentives for nurses to report concerns. Bjorkqvist (2000) Einarsen (2000) and Cowie et al. (2002) concur with Fox and Stallworth's (2003) point that whistleblowers who lose their jobs and most importantly their health in the process are affected economically, physically and emotionally.

Examples of Reprisals against Whistleblowers

Australia: Fong (1998) cites the story of Bill Toomer, a senior Western Australia quarantine officer in conflict with the Australian Federal Government for twenty five years, when he tried to uphold accepted standards of ship inspection and fumigation. Mr Toomer alleged senior public servants massaged quarantine laws to protect foreign shipping interests. The response to his allegations was disciplinary action, demotion and a punishment transfer to a remote area. Mr Toomer was forced to undergo psychiatric assessment, which provided grounds for suspension from his position for almost a year based on a diagnosis of 'mental imbalance'.

Ahern and McDonald's (2002) study confirms referral of whistleblowers for psychiatric analysis is common, and intended to promote the illusion of

mental imbalance in the employee who speaks out. Koryagin (1989) states, 'forcing whistleblowers to see psychiatrists in order to discredit them, usually as having a personality disorder, in order to account for their irrational obsession with malpractice, is reminiscent of society's misuse of psychiatry' (p. 338).

After 25 years, a 1995 Senate Committee Inquiry found the Federal Government had misused the psychiatric assessment of Mr Toomer to silence his allegations and remove him from his position. The Inquiry exonerated Mr Toomer and considered compensation was due, but Mr Toomer's application for compensation occurred outside the six-year maximum period allowable for cases such as his. Mr Toomer stated, 'employees who speak out can expect loss of innocence, loss of dignity, loss of employment and loss of lifestyle' (Fong, 1998, p. 9).

United Kingdom: In 2002 Marta Andreason, a former chief accountant of the European Union (EU), spoke out against its Enron-Style bookkeeping system (Evans-Prichard, 2004). Ms Andreason was suspended from her job in May 2002 for transgressing hierarchical lines, when she contacted the Court of Auditors after superiors ignored her warnings that the EU's sixty-three billion pound budget was 'an open till waiting to be robbed' (p. 27). Ms Andreason's complaint was that the EU did not use the double-entry bookkeeping system that was standard in the public sector; a system, which allegedly made it impossible to redirect large sums of money without leaving

an electronic fingerprint. She claimed she had found a £130 million discrepancy between two sets of books; the variance has never been fully explained.

The EU's senior auditor stated Ms Andreason's claims were factually and substantially correct. However, the EU imposed their harshest sanctions on her when she was dismissed without pay after a twenty-eight-month inquiry.

United States of America: Bristol-Myers Squibb and Apothecon Inc. agreed to pay more than five hundred and fifteen million dollars to settle civil suits over fraudulent drug marketing and pricing schemes. The claim included settlement for illegally promoting an antipsychotic drug to children and the elderly. Whistleblowers were not identified by name; however, six whistleblower lawsuits against the company were made from the state of Massachusetts, and one from the state of Florida. Fraud settlements were arranged with the federal prosecutors in Massachusetts for \$885 million in 2001 and for \$704 million in 2005. Under federal law the whistleblowers will receive a total of \$50 million dollars as their share of the settlement (Saltzman & Kowalczyk, 2007).

Russia: Sergei Kharitonov worked at the Leningrad Nuclear Power Plant (LNPP) for 27 years. After exposing hazards at the power station, he was sacked. After a long legal battle his dismissal was deemed illegal. He applied for asylum in Finland (Alimov & Ponamarera, 2005).

South Korea: The Nobel Foundation (2000) provided an interesting account of a whistleblower in politics when Kim Dae-Jung entered politics during the Syngman Rhee Administration (1948-1960) when the incumbent party was becoming increasingly dictatorial. In 1961, he was elected to the National Assembly. However, three days after his election, the National Assembly was dissolved following a coup d'état led by Major General Park Chung Hee. In 1963 Kim was again elected to the National Assembly and emerged as a spokesman for the Democratic Party in 1965, becoming chairman of the party's Policy Planning Committee the following year. The incumbent president sought constitutional changes that would allow him to run for a third term; Kim spoke against the scheme at an outdoor rally. In 1971, Kim was chosen as the presidential candidate for the New Democratic Party running against Park, where he garnered forty-six percent of the votes. Shortly after the election, Kim experienced the first of five threats against his life. A year after the election, President Park imposed martial law and banned all political activities.

In August 1973, the Korean Central Intelligence agency abducted Kim from a Tokyo hotel. The plan to kill him stimulated strong reaction from the United States. He was released in Seoul a week later, but placed under house arrest. In 1979, President Park was assassinated and Kim had his civil and political rights restored. After a few months of political unrest, another group of soldiers seized power and Kim was again imprisoned on charges of

treason. In a military court in November of that year, he was sentenced to death, which was later commuted to life imprisonment and finally to a 20 year jail term.

In December 1982 Kim's incarceration was suspended and he was allowed to travel to the United States of America. In 1987 he was cleared of all outstanding charges and his civil and political rights were fully restored. He ran and was defeated in presidential elections in 1987 and 1992. In December 1997 he was elected to the presidency, which marked the transition of power from the ruling to the opposition party. He was instrumental in pursuing a policy of engagement towards North Korea.

Organisational Legitimacy and Whistleblowers

Rothschild and Miethe (1999) provide insight into why organisations act harshly towards whistleblowers. The employee who speaks out assumes a different role from that which encompasses the work that they do. There is a shift of emphasis from their job role, and of their legitimacy, from employee to whistleblower. According to Sawyer, Johnson, and Holub (2006) the employee becomes negatively correlated with organisational legitimacy. This negative correlation directly influences the whistleblower's future.

According to Suchman (1995), organisational legitimacy can be achieved on three levels: pragmatic, moral and cognitive. Pragmatic legitimacy reflects the values the organisation displays in its activities such as aims, objectives,

protocols and policies. Moral legitimacy is more nebulous, in that it is the organisation's display of its ability to do what is expected as the right thing. Cognitive legitimacy relies on the provision of what conferring entities believe are acceptable elucidations of the organisation's practices.

According to Sawyer et al. (2006), pragmatic legitimacy determines organisational operational viability. For the whistleblower, pragmatic legitimacy lies in the ability to exchange, influence and share values with others. When an organisation exerts its authority over a whistleblower by means of dismissal, demotion or negative performance assessments, the intent is to minimise the pragmatic legitimacy of the whistleblower. It is well documented the whistleblower does not anticipate reprisals or retaliation at the time of speaking out (Ahern & McDonald, 2002; D. Jackson et al., 2002; Lennane, 2000; Martin, 1998; Rowell, 2005). 'Blowing the whistle' and establishing moral legitimacy usually undercuts the whistleblower's pragmatic legitimacy. This divergence between moral and pragmatic legitimacy positions the act of whistleblowing as the keystone of legitimacy theory (Sawyer et al., 2006).

Australian Whistleblower Protection Legislation

In Australia, the first whistleblower legislation was enacted in South Australia in 1993, followed by legislation in Queensland, the Australian Capital Territory and New South Wales in 1994. It was not until 2001 that Victoria enacted its whistleblower legislation, followed by Tasmania in 2002

and Western Australia in 2003 (New South Wales Ombudsman, 2004). It should be noted that although eight Acts and three Bills across Australia address the subject, none offers definition of the terms 'whistleblower' or 'whistleblowing' (Moss, 2007).

The purpose of whistleblower protection legislation is, as Dawson (2000) notes, to discourage workplace retaliation against employees who speak out. Throughout the developed world there is documented evidence of legislation to protect whistleblowers; however, while legislation exists, it provides little or no deterrent from workplace reprisals against those who speak out publicly. In De Maria and Jan's (1997) study, seventy-one percent of respondents who had spoken out publicly to some degree about workplace concerns confirmed they had experienced official reprisals from management, with ninety-four percent stating they had incurred unofficial reprisals, that is to say retaliation, from co-workers as well. Such unofficial reprisals against perceived 'dobbers' are difficult to investigate because the alleged actions are often ambiguous and deniable. Zipparo (1999) lists ostracism and social isolation as the most common forms of reprisal against whistleblowers, and notes that this type of occurrence is commonly found in rural areas where work and social life overlap.

The negative correlation between the legitimacies of the organisation and those of the whistleblower underpins the necessity to protect the whistleblower from reprisals, disadvantage and abuse. Vaughn, Devine and

Henderson (2003) confirm in recent times there has been an explosion of whistleblower protection legislation in countries such as the United States of America, the United Kingdom, Canada and Australia, as well as in other countries in Europe and Asia. While this is encouraging, it should be noted in Australia, where whistleblower legislation has existed for over a decade, there has not been a single case brought against organisations or agencies that have persecuted, dismissed or abused whistleblowers: as (Moss, 2007) says, Australia has a long way to go in producing uniform laws that protect whistleblowers. Attempts by both the Queensland and South Australian governments, who have trialled single national legislative regimes, have produced unsatisfactory results.

Table 1: Australian public sector whistleblowing legislation in chronological order of achievement by Australian states and territories

	Act/bill	Jurisdiction
1	Whistleblowers Protection Act 1993	South Australia
2	Whistleblowers Protection Act 1994	Queensland
3	Protected Disclosures Act 1994	New South Wales
4	Public Interest Disclosure Act 1994	Australian Capital Territory
5	Public Service Act 1999, section 16	Commonwealth
6	Whistleblowers Protection Act 2001	Victoria
7	Public Interest Disclosures Act 2002	Tasmania
8	Public Interest Disclosure Act 2003	Western Australia

Source: (Brown, Latimer, McMillian, & Wheeler, 2007, p. 1)

Table 1 shows the approach and commitment by Australian states and territories to create whistleblower legislation that is consistent and enforceable across the nation has not been achieved. An interesting point is that the focus and extent of authority accepted by each of the states and territories is governed by the range and focus of the chosen legislation. For example, South Australia, Queensland and Victoria adopt a Whistleblower Protection Act, where the focus is on the whistleblower. New South Wales adopts a Protected Disclosure Act, where the focus of protection is on the disclosure, not on the whistleblower. The Australian Capital Territory, Tasmania and Western Australia all adopt a Public Interest Disclosures Act where a whistleblower may make a confidential disclosure; however, there is no guarantee of protection. The Commonwealth – comprising all the states and territories – has adopted a Public Service Act which at the very least, is inconsistent with existing legislation and at worst, is highly confounding; for if whistleblowers are nurses, they are also public servants. Does this mean the whistleblower is subject to the individual law of the state or territory of residence, or of Commonwealth legislation, or both? It is clear the various legislations across Australia are inconsistent. This fact provides understanding as to why whistleblower legislation is inconsistent and to date has been unenforceable (Vaughin et al., 2003).

Table 2: Legislative requirements for internal disclosure procedures

Legislation		Agency procedures for			Agency procedures must follow model code/guidelines
		How disclosures can and should be made	Investigation of and action on disclosures	Protection of people as a result of disclosures	
1.	SA 1993	Nil			
2.	Qld 1994	Contemplated, but not required	Nil	Required	Nil
3.	NSW 1994	Contemplated, but not required	Nil	Nil	Nil
4.	ACT 1994	Required	Required	Required	Nil
5.	Cth 1999	Required	Required	Nil	Nil
6.	Vic 2001	Required	Required	Required	Ombudsman guidelines
7.	Tas 2002	Contemplated	Nil	Nil	Nil
8.	WA 2003	Required		Required	Commissioner guidelines

Source: (Brown, 2006, p. 46)

The literature (Brown, 2006; Brown et al., 2007; New South Wales Ombudsman, 2004) confirms what is demonstrated in Table 2: that the most obvious disparity between the current legislation pertains specifically to differences in coverage and jurisdiction of the legislation. Moss (2007) confirms whistleblowing law in Australia varies widely and is inconsistent in terms of definition of who can be named and what can be disclosed, the level of protection offered, and the severity of penalties for reprisals,

including breaches of employer obligations to workers (p. 9). These differences are important as they dictate which public officials and others such as family, friends or bystanders are eligible for protection, to whom a disclosure can be made, the types of wrongdoing covered, and the people or bodies about which disclosures can be made (Brown et al., 2007, p. 264).

De Maria (2002) notes of all whistleblowers, those who speak out to the media are at most risk of reprisal and retaliation, but they are not afforded protection by current legislation. If complaints are raised via internal schemes, internal bureaucracy is designed to override the voice of the whistleblower and negate their influence. A whistleblower who briefs a journalist on matters of public maladministration or corruption remains highly influential by virtue of the act of bringing the information to the mass audience.

Moss argues:

a strong case can be made for uniform public interest disclosure legislation. A new model federal law should at least protect whistleblowers who disclose to the media after making a reasonable attempt to have the matter dealt with internally, or where such a course was impractical. (2007, p. 9)

Sawyer et al. (2006) consider 'the negative correlation of the pragmatic legitimacies of the organisation and the whistleblower ensures whistleblower

laws are difficult to enforce', and conclude these laws appear to have been designed to deter, not to prosecute. (p. 14)

Risk to the Researcher in the Conduct of Sensitive Research

Martin (1998) describes research into whistleblowing as fraught with difficulties. A literature review on researcher harm (Dickson-Swift, James, Kippen, & Liamputtong, 2006) finds evidence of both physical and psychological harm. Two qualitative researchers have died: Ken Pryce, who studied West Indians living in Bristol, disappeared while studying criminal activity in Jamaica. His body washed up on a Caribbean beach. Myrna Mack, an American anthropologist, was murdered by Guatemalan paramilitaries. The details of these deaths were examined in an Inquiry titled *Qualiti (Qualitative Research in the Social Sciences: Innovation, Integration and Impact)* commissioned by the National Centre for Research Methods at Cardiff University to look into the physical and emotional harm suffered by qualitative researchers (Bloor, Fincham, & Sampson, 2010).

While there is physical risk to some researchers of contracting diseases such as hepatitis and malaria when conducting fieldwork in developing countries (Lopez & Willis, 2004), emotional harm is a more prevalent risk to qualitative researchers (B. Johnstone & Macleod Clarke, 2003). Over the past few decades, community awareness of issues such as domestic violence, child abuse and societal crisis situations have, according to Cowles

(1988), prompted research aimed to increase understanding and awareness of the experience of sensitive issues on peoples' lives.

Emotional upset can occur as a result of exposure to traumatic events such as those described by Coulter (2005) when she witnessed female circumcision rites. The literature also describes imposed researcher learning by witness of painful events such as interviewing participants involved with sexually abused children (Bloor et al., 2010). Symptoms including headaches, gastrointestinal disturbances, sleep disturbances and nightmares, anxiety, panic attacks and depression have been reported by researchers who have participated in this type of research (Burr, 1996; Cowles, 1988; Dickson-Swift et al., 2006; Gregory, Russell, & Phillips, 1997).

McCosker, Barnard and Gerber (2001) state methodological considerations in the conduct of research have been widely explored in terms of validity and reliability in qualitative inquiry. However, the literature is sparse on the pragmatic issues and experiences of qualitative researchers conducting research. Exposure of the researcher to sensitive information and experiences by the participants in this current research project was often challenging and at times uncomfortable. This experience was quantified by Kidd and Finlayson (2006), who said researchers experience 'new levels of understanding of the profound experiences of the participants by ...

harnessing these uncomfortable experiences as a conscious method for producing worthwhile research' (p. 426).

Qualitative interviews have the potential to incite painful memories and hidden feelings. According to Kidd et al. (2006), this is true for the participant observer undertaking sensitive research, particularly if the participants are known to each other.

Previously unknown or unexplored issues, emotional intensity and professional responsibility can render the researcher vulnerable even as the work contributes richness, depth and complexity to the human inquiry. Protection of the researcher from the effects of exposure to sensitive research is not widely discussed in the literature, although McCosker et al. (2001) consider the degree to which the researcher is likely to become emotionally exhausted and overwhelmed by the experiences of the participants may be extreme. It is therefore prudent, as recommended by Cowles (1988), to limit episodes of exposure to sensitive data by planning and limiting the number of interviews undertaken each week.

Transcription of data from audio tape to text, according to McCosker et al. (2001), can provide a unintentional, negative, experience between the transcriber and the participant as the data are inadvertently shared. For the benefit of the proposed and future research, the transcriber may be encouraged to journal their thoughts and feelings as an expression of the

experience of transcription of sensitive data (Wilde, 1992). Gregory, Russell and Phillips (1997) state in any research proposal, in terms of safety and the quality of the research, not only the researcher but also the transcriber of the data should be included in the research ethical clearance process, by declaration of the type of research, and warning of the potential for challenging or difficult interviews. It is also recommended regular debriefing sessions with access to crisis counselling be made available for all personnel involved with the data.

Conclusion

This literature review has examined the key issues relevant to whistleblowing as well as to issues associated with the participants of this study, who were nurses employed in the NSW public health system. Labelled whistleblowers by the media and colleagues, these nurses spoke out publicly about issues of patient advocacy and patient safety. As observed in other developed countries, in Australia, a nurse's primary responsibility is to his or her patient. The literature indicates nurses will go to great lengths to protect their patients even if that means acting outside what would be defined as an acceptable scope of practice and by being maternalistic towards their patients.

Codes of ethical practice for nurses acknowledge advocacy as an inherent element of professional practice that demands active participation in the minimisation of risks to patients while fostering high-quality practice

environments. The literature review reveals while advocacy is a desirable quality in a nurse, it renders the nurse vulnerable to criticism if the matter becomes public.

The Australian cultural tenets, 'you don't dob in a mate' and 'do-the-right-thing', are part of everyday Australian life and an inherent part of workplace practice. While intended to promote intrinsic, ethical behaviour and responsibility in nurses to advocate for and protect their patients, it seems the very heart of ethical Australian work practices creates difficulties for those who speak out publicly. 'Dobbing in a mate' is considered un-Australian, with whistleblowers being labelled 'rats', 'squealers' or 'dobbers'; they are likely to be rewarded not with praise, but with reprisal from all levels of the nursing and organisational hierarchies.

The NSW Health Department has adopted a zero tolerance to violence and bullying policy, which to date seems to have provided little protection for nurses from a bullying profession that employs retaliatory, horizontally violent, mobbing tactics against whistleblowers. This literature review reveals that the legacy of speaking out publicly for whistleblower nurses is psychological terror inflicted by work colleagues and supervisors, which may affect the nurse for the rest of his or her personal and professional life. Reprisals and punishments are brutal, designed to destroy the nurse's self-confidence, employability, financial security, seniority and career longevity.

Whistleblower laws in Australia are inconsistent, offering little or no protection to nurses and no real deterrent against workplace reprisals. They are inconsistent in their definition of who can make a disclosure, what type of disclosure can be made and to whom, and what degree of protection can be afforded to the person who speaks out.

Chapter 3:

Research Design and Methodology

Whether in the field of psychology, sociology, linguistics or history, the human element cannot quite be reduced to a scientific norm; there is always a residuum of uniqueness which does not fit the abstractions and generalisations in which the scientist would like to enclose it. The human being is thus difficult to handle; the best solution of course, is to suppress him (sic), or to declare that he (sic) no longer exists. In this way, science could really take over and work out theories no human element could contradict.
-Chiari

This research project was divided into three parts – pre, during and post whistleblowing event and was conducted using semi-structured, in-depth participant interviews. The participants were five registered nurses (one of whom is the participant observer/researcher) and one enrolled nurse. At the time of the interviews, all participants were permanent employees holding various nursing roles within the NSW public hospital system. At the time of the whistleblowing events, the six participants were employees of three different hospitals within the same Area Health Service within the state of New South Wales.

During the data collection, the participants were encouraged to tell their own stories using their own words. The data are intended to represent the stories as told by the nurses. There has been no attempt to improve upon any grammatical errors in the quotations presented here. The data were sorted into concepts that were then grouped into themes. This information provided the foundation for the subsequent interview questions.

A qualitative methodology employing descriptive ethnography was applied in this study. This research attempts to understand the perceptions and experiences of six women from three public hospitals in NSW who were labelled whistleblower nurses. An ethnographic methodology is appropriate for the conduct of this research. The central concept that underpinned the study was to gain an understanding of the whistleblower nurses' experiences in terms of their human, professional, political and social journeys related to these serious and eventually very public events in the history of NSW public health.

Anthropology, or the study of human behaviour, became an academic discipline in the 19th century. The questionnaire was the principle method used to gather population-based data (D. Madison, 2005). Intensive study of human behaviour or critical social theory, according to D. Madison, 'has evolved from a tradition of intellectual rebellion' (p. 15). Spradley (1979) defines it as:

A culture studying culture. It consists of a body of knowledge that includes research techniques, ethnographic theory and hundreds of cultural descriptions. It seeks to build a symbolic understanding of all human cultures from the perspective of those who have learned them.
(p. 27)

D. Madison (2005) notes ethnographers create layers of knowledge within their analysis. This is achieved to 'articulate hidden elements and

ambiguities, to promote observance and understanding of the critical expressions within different interpretive communities relative to their unique customs, symbols and codes' (p. 96).

Nelson, Treichler and Grossberg (1992) describe qualitative research as an 'interdisciplinary, transdisciplinary and sometimes counter disciplinary field that traverses the humanities as well as the social and physical sciences' (p. 4). Denzin and Lincoln (2011) state 'qualitative research as a set of methodological activities privileges no single methodological practice over another', and that qualitative researchers use 'semiotics, narrative, content, discourse, archival and phonemic analysis – even statistics, tables, graphs and numbers' (p. 6). Qualitative research, according to Denzin and Lincoln 'draws on approaches, methods and techniques applicable to ethnomethodology, phenomenology, hermeneutics, feminism, rhizomatics, deconstructionism, ethnographics, interviews, psychoanalysis, cultural studies and participant observation among others' (p. 6). Nelson, Treichler and Grossberg (1992) state 'these research practices can provide important insights and knowledge' (p. 2). Bateson (1972) states, 'all qualitative researchers are philosophers in that unusual sense in which all human beings ... are guided by highly abstract principles' (p. 320). Denzin and Lincoln (2011) see the approach as threefold:

These principles combine beliefs about ontology (What kind of being is the human being? What is the nature of reality?), epistemology (What

is the relationship between the inquirer and the known?), and methodology (How do we know the world or gain knowledge?).' (p. 12)

Gupa (1990) and Denzin and Lincoln (2011) also see qualitative research consisting of three main interconnected activities, 'theory, method, and analysis or ontology and epistemology' (p. 11).

Ethnography is the work of describing a culture. Ethnography as a research method facilitates researcher insight into the participant's perceptions and experiences of events. Ethnographic inquiry is an appropriate methodology for this research. It was necessary to gain insight and understanding of the participant's individual experiences and to quantify each subsequent formal as well as informal outcome and consequence. In support of this type of research, Denzin (1978) notes that ethnography enables the researcher to go beyond the static organisation and experience social and work place practices as the participant experiences them.

The decision to employ a qualitative methodology in the form of ethnography was made for the 'freedom' (Lopez & Willis, 2004, p. 729) afforded the researcher by this type of research. Heidegger (1962) asserts human experience is entrenched in its social surroundings and is reflected in the subjective representation of social, cultural and political experience. This concept is termed 'situated freedom' by Leonard (1999, p. 319), and is defined as 'an existential phenomenological concept that means humans are

free to make choices, but their freedom is not absolute; it is circumscribed by the specific conditions of their daily lives' (Lopez & Willis, 2004, p. 729). The intent of this research was to capture the voice of each of the participants and gain an understanding of their experiences as social beings. The decision to employ a qualitative methodology follows the principle articulated by Annells (1996), that research findings must be 'logical and plausible within the study framework, and they must reflect the realities of the study participants' (p. 710).

Assumptions and Limitations

This research project is limited to the experience of five registered nurses and one enrolled nurse; however, comparison is made to similar studies of the lived experiences of other nurses who have spoken out publicly about patient care or patient safety. This project explores the assumption that nurses who speak out do not view themselves as whistleblowers: rather, they may see themselves as professional nurses enacting their professional responsibility as their patients' advocate. The question must then be asked: is there such a thing as a nurse whistleblower, or is this a term employed by the media in an effort to sensationalise poor patient outcomes while deliberately detracting and devaluing the onerous role advocacy plays for nurses? It was not the objective of this research to relate the legal findings of any of the formal inquiries, with the experiences of the nurses: the pivotal point is to understand the individual experience of each of the nurses from

the time of speaking out publicly and across the subsequent ten years of being labelled a whistleblower.

Formal Identification of the Participants and Collection of the Evidence

It was important to this study to acknowledge a pre-existing, professional relationship between the researcher and the other five participants. The researcher, as a professional colleague of the nurses, was also identified as a whistleblower nurse in the Independent Commission against Corruption (ICAC) and the Legislative Council (2006) Inquiry into complaints handling of three public hospitals in the state of New South Wales. To impose rigor in the selection of the participants of this study, it was necessary to review reports from government agencies and their investigations into complaints handling by the NSW Health Department. The researcher's personal experience of whistleblowing and inside knowledge of the experiences of the other nurses provided the catalyst for the principal supervisor of this study to distribute invitations to these nurses (and also 'Narissa') to participate in this research. All except Narissa responded and agreed to participate.

Preparing for the Interviews

The nurses

This study was undertaken by a participant observer, one of six nurse participants directly involved in raising issues of patient safety and patient advocacy before a General Purpose Standing Committee Inquiry into

complaints handling within NSW Health. The researcher also shared a professional relationship with all but one of the other participants in this study.

When the nurses' stories became public, the researcher, through social acquaintances, gained contact information for each nurse. Details of the enrolled nurse were obtained from the participant identified as Yanaha. Following initial telephone contact with each of the participants by Kathrine, the research supervisor emailed each nurse inviting her to participate in the study. Once the participants had indicated a willingness to participate, hardcopy consent forms which included an overview of the study (Appendix 1 and Appendix 2) were distributed via Australia Post with postage paid envelopes included for the return of signed consent forms.

The study setting

The researcher was aware of the need for sensitivity in the construction of the interview questions. It also was important to guarantee participant privacy. Gopal and Prasad (2000) state in a interactionist ethnographic study research should be conducted in a natural setting to enable access to viewpoints of the situation through prolonged exposure to the subject. It was therefore important to meet the participants at a venue of their choosing, to ensure they could speak freely and confidentially. Venues were negotiated directly with the participants and interviews scheduled around their availability. It was agreed at the outset that the participants should

contact the researcher and reschedule interviews if a situation arose that made the interview date and time unsuitable.

All of the interviews, at the behest of the participants, were conducted at their individual private residences. It was interesting to note on visits for the second and subsequent interviews, the familiarity of the setting seemed to impact positively on the free flow of dialogue.

The Interviews

Following an extensive review of the literature, semi structured, in-depth, participant interviews were undertaken which consisted of open-ended, probing questions to facilitate the free flow of conversation in an attempt to capture accurate, individual recollections and stories.

Examples of questions from the initial round of research

(To Yanaha): You stated the Nursing Unit Manager was part of the problem, what do you mean by that?

(To Violet): When you said your friends were afraid that you would do something, did you contemplate taking your own life? What happened to make your friends fearful for you?

(To Simone): You have stated your marriage has been affected by this experience. Can you tell me what changed specifically in your relationship with your husband as a direct consequence of this experience?

Open-ended questions were asked across the scope of the interviews. It was important that the same questions were asked of each participant, ensuring as much as possible a uniformity of questioning. There was however flexibility in the questions to allow for individual responses. This was to ensure all the voices and stories of the participants were heard. Manias (2001) in support of this approach suggests that to do otherwise 'is to risk the establishment of one form of ethnographic truth rather than the real truth' (p. 240).

Gopal and Prasad (2000) state 'research questions need to focus primarily on the symbolic and emergent aspects of the phenomena being studied, with emphasis on local and shared interpretations' (p. 511).

Examples of open-ended questions

(To Simone): You mentioned earlier in the interview about the darkness ... you experienced darkness. What does that mean?

(To Meadhbh): What do you believe are the consequences that nurses can expect if they blow the whistle?

(To Simone): Can you describe the consequences you believe you may have experienced as a result of speaking out?

Scheduling of the interviews

Each nurse was interviewed three times over an eighteen month period. The intervals between each interview ranged from six to nine months. The purpose of staggering the interviews was to capture the progressive story of

the reasons why each nurse chose to speak out and the effects of becoming involved in the subsequent investigations. The plan was to conduct three interviews, to determine what happened to each of the nurses, what the outcome was and what the future held after the whistleblowing events. Provision was made for additional interviews should there be unanswered questions about the individual experiences of the participants.

First round of interviews

The purpose of the first round of interview questions, shown in Table 3, was to gain an insight into the person and to gain an understanding of:

- a.** How and why the participant became a nurse.
- b.** What it means to be a nurse.
- c.** What happened to cause the participants to speak out publicly.
- d.** To learn, if the participants had their time again, would the same choices be made again, and why?

Table 3: Questions in the first round of interviews

<p>What did nursing mean to you prior to the whistle-blowing event?</p> <p>What were the circumstances that led to raising issues of concern with your employer?</p> <p>How did the information become public?</p> <p>If you had the opportunity to go back to a time prior to the events that happened to you, would you make the same choices?</p>

Examples of questions from the first round of interviews

- Can you tell me why you became a nurse and give me an overview of your nursing career?
- So you became a critical care nurse: can you talk about the event that you got caught up in?
- Can you talk about what happened after the information became public?

It was important to this study to confirm the professional credibility of each of the nurses along with their level of seniority and range of professional experience. The interviews in this round each lasted between one and a half and two hours. The transcribed data from this first round equated to 118 pages or 57,845 words.

Second round of interviews

Table 4: Questions in the second round of interviews

What (if any) were the physical, psychological, social or professional effects, you perceive you experienced as a result of being labelled as a whistleblower?

Can you describe the role of the industrial body representing New South Wales Nurses in your whistleblowing experience?

Nurses have professional practice boundaries. Have you ever worked outside of what you know to be your lawful scope of practice?

Having experienced being labelled, what now is your definition of a whistleblower?

Through the course of these interviews, you may have relived your whistleblowing experience. Given those reflections, if you had the opportunity to go back to a time prior to the events that happened to you, would you make the same choices?

The questions from the second round of interviews, presented in Table 4, were designed to gain an understanding of:

- a.** The scope of the consequences of speaking out.
- b.** The role (if any) of the industrial body representing nurses.
- c.** Scope of professional practice.
- d.** Labelling of whistleblowers.
- e.** Whether the participant would make the same choices again.

Examples of open-ended questions in the second round of interviews

- When you decided to speak out, what were the reactions of your colleagues, supervisors and family?
- What is your definition of a whistleblower?
- Do you fit your description and why?
- After everything that has happened ... are you different?
- If you could compare the person you were before these events occurred with the person you are today, how do those two people compare?

The question 'If you had the opportunity to go back to a time prior to the events that happened to you, would you make the same choices?' was posed to capture any variance from the answer given in the first round of interviews. This question was deliberately repeated to elicit the effect (if any) the revisit of the whistleblowing experience in the first round of interviews had upon the participant's feelings towards whistleblowing.

The interview process often resurrects unpleasant memories. This research offers the collective effect that being labelled a whistleblower has had upon the professional, personal, and family lives of each of the nurses as social beings. This round of interviews averaged between one and a-half to two hours per session. The transcribed data from this second round of interviews equated to 110 pages or 39,610 words.

Third round of interviews

Table 5: Questions in the third round of interviews

Do you think there have been any long-term consequences for you professionally and what does that mean for you as a nurse in the future?

Can you quantify the consequences you believe you may have experienced as a result of speaking out? For example financial, family, personal, social and personal implications?

Has your experience as a whistleblower nurse affected how you feel about telling the truth about adverse patient outcomes and patient safety?

Do you think you have changed your practice ... have you created some way of keeping yourself safe now?

Do you believe there is a need to protect nurses who publicly advocate for their patients?

On completion of each of the interviews did you experience any feelings, symptoms, flashbacks or concerns?

The questions from this third and final round of interviews, presented in Table 5, were designed to determine:

- a. The long-term professional consequences of speaking out and what, if at all, the participants foresee as their future in terms of continuing in the profession of nursing.

- b.** The financial, family, personal, social and personal implications associated with whistleblowing.
- c.** How the interviewees now feel about advocating for their patients and telling the truth.
- d.** How, if the nurses intend to continue to work as nurses, they intend to stay 'safe'?
- e.** Is there is a need to protect nurses who actively advocate for their patients?

Examples of open-ended questions in the third round of interviews

- What does the profession of nursing hold for you in the future?
- What do you believe are the consequences for nurses who blow the whistle?
- Has this event effected how you plan to work in the future?
- Again, the question was asked, 'If you had the opportunity to go back to a time prior to the events that happened to you, would you make the same choices'?

The plan to repeat this question at the completion of all three interviews was sound. The participants in the final interview all, as a result of participating in this study, demonstrated escalated emotion and strong feelings about how they feel about being labelled whistleblowers.

This round of interviews averaged between one and one and a-half-hours per session. The transcribed data from this third round of interviews equated to 73 pages or 27,005 words. No further interviews were conducted as data saturation was achieved, with no new themes being identified.

Interpretation of the Data – Thematic Analysis

The interview transcripts were read repeatedly before any attempt was made to group the data under common themes. The data were colour coded into numerous micro themes, which were then grouped into macro data sets for the telling of the nurses' stories and analysis of the data. The issues found to be important to the participants evolved into thematic sets which determined the direction used in this research. Minichiello, Aroni, Timewell and Alexander (1996) note that it is usual to code or group data, transforming the story told in the participant's own words into an understandable account of the similar social experiences of different participants.

Tuckett (2005) offers a five step-process of thematic analysis: (1) the collection and coding of the themes in the data, (2) making comparison of the data and identifying common and differing features, (3) identifying themes and sub themes, (4) using the themes to tell the story, (5) reviewing and considering the identified themes to ensure appropriateness and relevance to the proposed research. This was the process used in this

research; which enabled the researcher to construct an argument that whistleblower nurses may be different to other whistleblowers.

Themes Revealed in the Data

The desire to know each of the participants as individuals was achieved by asking questions that promoted understanding; the answers formed common themes. The intention of the interview process across the three rounds, was to identify:

- a.** What event caused each of the nurses to be labelled a whistleblower?
- b.** What were the consequences of speaking out?
- c.** After the whistleblowing event, what the future held for each participants?

The questions asked in the first round of interviews were designed to identify the professional persona of each of the participants. An example of a question from the first round of interviews is, 'So tell me about you the professional. Go back and describe how it all started ... what are your qualifications and where you are now in your professional life'. From this question the concept of wanting to be a nurse because of nursing's inherent caring qualities was revealed as a common theme across the study group.

The second interview question, 'What does being a whistleblower mean to you?' revealed each of the nurses reject the label and argue that patient

advocacy is not whistleblowing. In the final round of interviews, questions were asked about any plans each nurse had for a future, including working as a nurse. The question 'what does the profession on nursing hold for you for the future?' elicited an unexpected outcome. The common point made by each participant was that if she were to continue to practice as a nurse, this would only be possible in a workplace where the risk of being ostracised as a whistleblower was controlled and a perpetual, career vantage of safety established.

The themes identified within this research promoted an understanding of each nurse as a health care professional. The inherent qualities of professional nurses as identified in Chapter 1 were clearly identified as important to the participants. The consequences of speaking out were mirrored experiences, with plans for the future affected by the experience of being labelled a whistleblower. It was a poignant experience for the researcher to recognise her own experiences within the narratives during each of the interviews. The stories while different were startlingly similar in the description of the consequences that were experienced by each of the nurses as a corollary of speaking out publicly about patient care or patient outcome concerns.

The participants, with the exception of the researcher, were, (despite being formally identified in government agency evidence, Inquiry documents and media reports) offered *nom de plumes*. Much of the information regarding

each nurse's experiences is in the public domain. It was important to this research that the participant's in-depth interview stories were recognisable when aligned with the formal government agency reports. These reports formed part of the data collected for this research. The public hospitals involved in this study are not identified, but are referred to collectively as public hospitals within the state of New South Wales.

Data Collection and Storage

The participants consented to audio taped in-depth participant interviews which lasted between one and two hours. The audiotapes were stored within the researcher's locked filing cabinet, to which she is the sole key holder. The taped data were transcribed only by the researcher; they were transcribed verbatim and saved electronically onto the hard drive of the researcher's password-protected personal computer. Secondary storage of the transcribed interviews was provided back-up on two USB drives, stored in the researcher's locked filing cabinet. All hardcopy pages used in the editing process were shredded and destroyed.

Validation of the Data

The researcher, after converting the data from audiotape to text, returned transcripts of the interviews to the respective participants. Corrections and alterations were made on the advice of the participant to ensure the researcher had accurately recorded the participant's story, speech inflections

and statements. This process was continued until the participant indicated the text was true to their recollection of the interview conversations.

Ethical Considerations

The project was submitted to the University of New England Human Research Ethics Committee (HREC) for approval to proceed with the research. The commencement date was 15/01/2007. The committee approval number is HE06/164. There were no conditions placed upon the conduct of the research.

The researcher identified the potential for significant ethical dilemmas in the conduct of this research. It was important that the participant observer acknowledge obvious ethical concerns because of her direct involvement in some of the original allegations and in the subsequent investigation into complaints handling by the hospitals. As the data collection progressed it became apparent to the researcher there was a significant risk of bias in favour of the informants due to their past relationship with the researcher. It was, and remains, important that the issue of potential bias be recognised and acknowledged within this study.

Participant Observation

Participant observation is an observational research method in which the researcher is involved as a participant in the study (Dane, 1990). The participant observer role provided this researcher with a unique opportunity

into the insights and experiences of the participants involved in the investigations into complaints handling. Gerrish (1997) states although there are principles of ethical practice applicable to research, there are no clear guidelines as to how these principles should be applied to the participant observer. Hammersley and Atkinson (1994) confirm it is the responsibility of the ethnographer to act in ways that are ethically acceptable, taking due account of his or her goals, the situation in which the research is being carried out, and the values and interests of the people involved.

The experience of being a participant observer in this research was at times distressing and challenging; made more difficult by the prior professional relationship of the researcher with some of the participants. A constant threat to this research revolved around the researcher's need to impose no further distress upon the participants. The greater the distress expressed by the participants, the more the researcher unconsciously narrowed the level of inquiry in an attempt to not cause further harm.

The pursuit of knowledge through research is at times conflictive, with the need to achieve understanding and insight sometimes at odds with ensuring all the participants are treated fairly. Erickson (1967) states 'researchers must balance their obligations to promote intellectual freedom and contribute knowledge with fair treatment of the very people to whom these obligations are owed and to whom the knowledge is to be distilled' (p. 395).

It was essential to this research that the participants were willing to engage in conversation without feeling obligated (because of the pre-existing relationship with the researcher). It was also important to represent the experiences of the participants accurately, by letting their words rather than the words of the researcher tell their stories. Dane (1990) makes reference to the right of participants to make up their own minds freely about subjecting themselves to scrutiny in research

Two separate issues affect voluntary participation in research: coercion and awareness (Dane, 1990). Coercion includes the use of threats or force or affecting greater compensation than would reasonably be expected to achieve a desired outcome. A pre-existing relationship between the researcher and a participant could be viewed as a source of coercion within this study. In this enquiry, the researcher recognised because of pre-existing relationships, the participants may have felt obliged to participate in the study. This fact was discussed when the research was explained, before the consent forms were distributed. Kidd and Finlayson (2006) said the researcher has the onus of being responsible for the depiction of 'charted territory', which includes the safe navigation of issues such as confidentiality, anonymity and ethical consent, with full disclosure of the intent of the research (p. 423).

It was important to this research that the participants were encouraged to make up their own minds and tell their stories freely, or choose not to

participate at all. Duffin (2001) agrees indemnification of whistleblower nurses is essential if the consequences of whistleblowing as documented in the literature are to be avoided by nurses of the future. Voluntary participation includes not only awareness of being part of the research, but also of the scope of the project and what is being reported upon.

The researcher was explicit in the definition of the scope, aims and objectives of the research project for the participants (Appendix 2). It was important the participants were offered sufficient information about the research to allow them to make an informed choice about participating in the study. The principles of this study reflected Fontana and Frey's (1994) advice, 'as field workers, we need to exercise common sense and moral responsibility to our subjects first, to the study next and to ourselves last' (p. 124).

Beauchamp (2008) describes the principle of beneficence as the act of doing no harm. The researcher, by professional association, was aware of the stressful circumstances by which the nurses came to be labelled whistleblowers. Participant observer researchers not only hear the stories, but in the course of their research revisit the stories repeatedly, risking escalation of symptoms such as distress. In recognition of this possibility, it was important to this researcher to first recognise the potential risks, and then to plan the research, finding a balance between the need to understand

the human situation, to capture the story, and to protect both the researched and the researcher.

While few incur actual physical harm during the conduct of their research, it was necessary for the researcher to ensure each of the participants were aware of the possibility of psychological harm as a result of reliving the trauma of the whistleblowing event. If the participant appeared distressed, the researcher changed the line of questioning or terminated the interview (with an explanation made in the text as to the participant's response at the time). Participants were provided information about publicly available counselling services, should they need them.

There were times during this research when questions had the potential to be distressing for the participant. An example of such a question was, 'Can you tell me what, if any consequences you perceive you have incurred as a result of being labelled a whistleblower?' In recognition of the potential for upset, the researcher acknowledged the pain and suffering such a question might pose. The participants were all advised if a question was too confronting, they could move on to the next question as the researcher in no way wanted to cause harm or undue duress.

The Potential for Bias

Insider–outsider controversy

According to Minichiello et al. (1996) insider–outsider controversy occurs when the participant observer has some understanding of, and insight into, issues that are identified as relevant and important by the participants (pp. 182-185). Before the conduct of this study, the researcher had been a professional colleague of all but one of the participants. It was/is important for the researcher to acknowledge political and professional empathy for them because of their shared experience, as well as acknowledging them as her professional colleagues.

Borbasi, D. Jackson and Wilkes (2005) state participant observation is 'generally synonymous with field work and a technique for data gathering through processes that blend observation, questioning and listening' (p. 500). Kite (1999) describes the advantages of participant observation as the researcher moving from the emic (the insider's view) to the etic (the outsider's view), seeing 'from the inside with the eyes of an outsider' (p. 47). Her analogy of the participant observer as both a 'stranger and a friend' is relevant to this research.

Participation in sensitive research

Social research, according to Lalor, Begley and Devane (2006), seeks to explore the experiences, feelings, emotions and the reactions to life-altering events of those experiencing the phenomena. Qualitative data are frequently

collected by repeated in-depth interviews when exploring sensitive issues such as grief and loss, and is frequently expressed in narrative form. Sandelowski (1991) points out while researchers aim to be sensitive and flexible during the collection of data, the narratives are influenced by the interview situation. Agreeing, Davies and Harre (1990) add narratives shift according to the power positions within the interview and discourses such as age, sex, gender and ethnicity directly influence how the narratives are offered and interpreted.

Fahey (2002) states qualitative research is achieved by collaboration between the researcher and the participant in the construction of knowledge. The dynamic of the human mind and the lived experience ensures there are many perspectives of each event. In qualitative research this finding is pivotal, as what is narrated is dependent upon the context, the listener and the intention (Alex & Hammarstrom, 2008).

The need for consideration of the wellbeing of vulnerable groups during the conduct of research is well documented (Rosenblatt, 2001; Rowling, 1999; Weaver Moore & Miller, 1999). R. Lee and Renzetti (1990) add researchers themselves are highly vulnerable to the heightened emotional responses experienced from the narratives extracted from interviews. Lalor et al. (2006) also notes the collection of narratives can involve significant distress for the researcher who is exposed to participants' emotion and grief (Kidd & Finlayson, 2006). Minichiello et al. (1996) point out qualitative research

exposes the researcher to sensitive often intimate recollections of human experience: when the researcher is also a participant, the risk of exposure to sensitive information is significantly increased, as personal recollections may escalate on hearing other similar stories and incite feelings, fears and memories that are detrimental to the researcher.

The Experience of Participant Observation in this Study

During the course of this study, the researcher, by virtue of also being a participant, experienced difficulty in the development of an appropriate scholarly scope of inquiry for the study; a scope that embraced the wider world experience of whistleblowing. Many times, unconsciously, the data would devolve into what was an exposé of, and was limited to, the experiences of the six nurses involved in this study. The focus of the study became narrowed and flawed, not by intent but by the need of the researcher to understand how six professional, highly qualified, highly skilled nurses, in the course of executing their various roles, could be lost to nursing and made lifelong professional pariahs. Only after her supervisors demonstrated how the thesis had taken an inappropriate detour was the work expanded and the direction of the thesis corrected.

Being a participant observer is a humbling and difficult experience. Ultimately it is a privilege to be offered intensely private information by colleagues. However, by virtue of association, a potential dichotomy occurred during the course of this study, a dichotomy that can only be

described in the researcher's words as an encounter with amoral curiosity: for the nurse and woman within the participant observer wanted to protect her colleagues from further harm, while the researcher deliberately sought to capture the experience and pain and express it as appropriate and scholarly research.

Researcher vulnerability

Kathrine, as a participant observer, already suffering from an acute anxiety disorder as a result of being labelled and punished as a whistleblower nurse, experienced extreme distress and psychological terror (Leymann, 1990, 2006) during her involvement in and conduct of this research. She identifies four factors which compounded the extreme reactions she experienced in the course of the study. First, with the exception of Simone, all the participants were known to her before she undertook the research. Second, she had held a senior position in which she was a supervisor to the nurses, which incited protectionist feelings towards the participants. Third, she discovered a perverse, amoral curiosity in her desire to hear the nurse's stories and capture their experiences and emotions while (fourth) she harboured a pervasive, underlying guilty hope that if she heard the nurses' stories she would not feel so alone and abandoned by her chosen profession.

Kathrine heard the participants describe feelings and reactions so similar to her own: 'It's a perpetual open wound for any bastard to throw salt in.' 'The fear keeps coming back and it's always going to be.' 'I hate life ... I hate life.

I resent the fact that I have to live life. I wish I wasn't here.' 'I contemplated jumping from a building ... a very tall building ... but I couldn't get the windows open. I don't think I really wanted to die ... I just wanted to escape.' 'I did not know how to handle the anxiety. I did not know how to control these scared feelings I had and this was all spiralling out of control. I had this fear, this absolute morbid fear.' Kathrine admits she now understands what Kidd and Finlayson (2006) describe as 'new levels of understanding of the profound experiences of the participants by ... harnessing these uncomfortable experiences as a conscious method for producing worthwhile research' (p. 426). Kathrine's vulnerability as the researcher posed a considerable threat to her psychological wellbeing, yet as Kidd and Finlayson (2006) recognise, 'it also added depth and complexity to human inquiry' (p. 423). Protection of the researcher by planning for safety.

Participant Observation and the Decision to Present Narratives/Findings in the First and Third Person

The position of participant observer within sensitive research is challenging; not only from the point of view that repeated exposure to sensitive data has the potential to harm, but in the deliberate identification and presentation of the participant observer as a subject within the group that is being studied. In this research it was important that the two roles undertaken by the researcher/participant be portrayed as recognisably separate entities. This decision was made to enable the researcher to be viewed clearly as a participant of the group that was studied. This stance also allowed the

participant observer's truths to be heard by identification as the speaker. The second voice – that of the researcher – allowed the experiences of the researcher to become another story within the study. The distinction between these two roles was important to the conduct of this research.

The participants knew the researcher as a nurse manager within the NSW public health system: a position more senior than any of the roles held by them. The researcher was conscious of the potential for modified truths to occur within the interviews because of the previous supervisory relationship and power differential she had held with the participants. Sandelowski and Barroso (2002) confirm narratives can be influenced by power differences during interviews. It was important to this study that the researcher and the participants discussed and acknowledged the potential for bias, and worked collaboratively to first acquire and then interpret the narratives within the interviews (Fahey, 2002).

Unconscious Influence upon the Truth by the Researcher

The participant observer's loss of career and status within nursing as a direct result of being a whistleblower raised the probability of unconscious influence and bias in the interpretation of the data. It was important to this study to recognise the potential for the participants to be abused by the researcher's *need* to tell the story. Alex and Hammarstrom (2008) point out that one's point of view of the world will impact upon the interpretation of narratives within research. In recognition of this possibility, the researcher

reported the stories of the participants as they were told, as much as humanly possible, without influence or subjective interpretation.

Potential for Conflict in Presentation of Results from Data

In the course of collecting data from Simone (an enrolled nurse), the researcher became aware that she had willingly acted outside what would be considered a reasonable and professional scope of practice for an enrolled nurse. The researcher, given her experience as a senior nurse manager, was experienced in the mandate for nurses to work within what is defined as a lawful scope of practice determined by the achieved training and education; her relationship with Simone had the potential for conflict when it became clear Simone had gone beyond this scope. It was important that the researcher hear Simone's stories not with the ears of a senior nurse manager, but as a qualitative researcher, and that she remain focused on the framework of the research and listen but not judge, if the issue of the scope of practice was to be critically explored.

Toffoli and Ridge (2006) state, 'when considering the effect of research upon subjects and researchers ... it is clear that the much vaunted insider ethnographic techniques have the potential to unsettle organisations and workers through the very process used to undertake the research' (p. 602). The researcher acknowledged the conflict she experienced when she heard Simone's scope of practice declarations; requiring her to consciously step back from the nurse manager role to enable Simone to tell her story.

Conclusion

The participant observer, with the support of her supervisors, recruited to this study five registered nurses and one enrolled nurse who had been named whistleblowers by their colleagues and the media. The participants, with the exception of Simone, were known professionally to the researcher. Three rounds of interviews were undertaken over eighteen months. The purpose of the interviews was to define the participants professionally and describe each of the events that led them to be labelled as whistleblowers, to explore the outcome of each nurse's experience, and to gain an understanding of what the future held for each nurse from both personal and professional perspectives. The concept of the participant observer was explored, and insight offered into what problems such as unconscious bias and prior relationships have upon the participant observer's experience, when the need to do no harm competes with the need to live the experience of the participant.

Chapter 4:

Truth Telling

If you are out to describe the truth, leave elegance to the tailor.
–Albert Einstein

Epistemology – the theory of knowledge – is concerned with truth. The world in which we live provides experiences that promote the acquisition and development of our own set of traditions, personal and religious beliefs: ‘Truth is perceived as the opposite to, or the absence of lie; truth is seen as a static object merely waiting to be described and verbalised; and medical truth is assumed to reside only in the objectivity of quantifiable data’ (Surbone, 1994, p. 2189). Different societies demonstrate complex and differential patterns of truth telling. This is why different practices and degrees of truth telling exist throughout the world (Surbone, 1997).

Telling the truth is associated with goodness, honour, integrity and high moral and ethical standards of behaviour. Truth telling is expected by and of nurses – by patients and other nurses alike. The therapeutic nature of the nurse/patient relationship is a central concept for nurses (Haines & Donald, 1998). Truth telling is also important to nurses, as evidenced by the voices of the participants of this study.

The Participants

Monique:

Aged forty-nine this year. Divorced with three kids, all grown up. I've been a nurse for many years. I started nursing in 1975. I finished [registered nurse training] in '78. I've worked in a lot of hospitals in a major metropolitan Area Health Service and the private [system] ... I became a nurse because I wanted to help people. When my father died, I just wanted to give back to people what was taken from me - actually wanted to be a policeman. I had a lot of anger and I wanted to be a policeman because you have the gun and you have the power ... but I chose nursing. I was one of those difficult children. I was labelled. If my dad was alive I would have shoved my [nursing] certificate up his nose because he always led me to believe that I would never amount to anything ... and I have ... I think I have achieved my goal, helping people, being a patient advocate and a staff advocate.

Meadhbh:

I am fifty-five years old, divorced in recent times with two grown children. I can remember the day that I went for my interview to be a nurse. In those days it was expected that you wore hats and gloves and looked very proper in your suit ... and I didn't, I wore a summer dress, which was a mini skirt! I sat in a sitting room with other girls in their brown suits (chuckle) and their gloves and their hats and the sun was splitting the rocks. They were hot and bothered and said 'You are wasting your time here; they are not going to give you your training here'. I walked into the room and the panel said, 'You are like a breath of sunshine'. I did of course get in to St James (hospital) in Dublin. I did my finals in '71 then I did my maternity in the Maternity hospital

and stayed on for five years. Then I went on to St James operating theatres and I moved out to Australia eleven years ago.

Violet:

I am soon to be thirty-nine, divorced with one child who is nearly eleven. Nursing to me wasn't just a job; it was really a passion for me. I absolutely loved it ... it was my contribution to the world. I did my Bachelor of Applied Science (Nursing) at university ... I went back (to university) for two years part time to do the degree ... then I did the coronary care course. I immediately after coming out of uni got a job at my local hospital on the new nurses program. I did my last three months in Intensive/Coronary Care and of course I liked it and never looked back. I finished my Intensive and Coronary Care course and became a clinical nurse specialist. I just liked being on the floor [working as a clinician]. I also loved education.

Yanaha:

I am 49 years old. I have three daughters and a husband. I am a nurse and I have been a nurse since I was sixteen years old. Nursing is an integral part of me, of who I am. I started nursing at sixteen, as a cadet nurse. I applied to do my training at a major Sydney referral hospital during 1974 and I was accepted. I didn't like nursing at all. In fact I hated it. I was eighteen by then and I thought nuh! I've made a mistake; this isn't what I should be doing. Then about half way through second year, when I was just about to throw it in, I did my first theatre term. I just remember walking in there, getting changed into scrubs and feeling like I had come home!

Simone:

I am thirty-seven years old, and was born in Sydney Australia. I am the eldest of three children. I have been married for thirteen years. I have been with my husband for twenty years. We have one daughter – she’s seven. All of my adult life I have been nursing. I trained at a Sydney hospital in the 80’s. I am a Buddhist. I am a very loyal person and I have quite high morals and a protective nature. I can’t stand injustice or intolerance or things like that. I can be quite outspoken in defence of people, not usually for my own defence, but for the defence of people who I feel need my defending. I am an enrolled nurse...

Kathrine: (The researcher, author and a participant observer in this study)

Participant observer, aged fifty something, happily married for more than two decades with two remarkable children. I am a nurse dinosaur. At seventeen, in 1978, I started my nursing training at a rural facility through the hospital training system. I clearly remember on a camping trip with my family when I about eight years old, I met a young woman who was sitting on the grass of a headland at Rainbow Beach in Queensland, she was reading what I now know to be a gynaecology/obstetrics textbook. As a pathologically social being, I talked to her and questioned her endlessly about the pictures in her book. I remember going back to the campsite with my mind full of these incredible pictures. My mom and I often laugh when we recall the moment when I innocently asked her if she knew how babies were born! After completing my general training in 1978, and midwifery in 1979 and throughout my career, from clinician to senior manager I have been greatly influenced by my father’s edict ‘do it right first time girl or don’t do it at all!’ As an Australian, did those words set me on an impossible course to ever seek truth and social justice not only in my own practice but also in the practice of others? ... Perhaps.

Narissa: (A non-participant in this study, – but a highly influential person).

A registered nurse with the nom de plume Narissa held the highest media profile of all the whistleblower nurses involved in the NSW public hospital scandal. In an Inquiry by the Independent Commission Against Corruption (2005b) it was conceded while Narissa 'is likely to have personally believed her assertions were true, it was formally concluded that the allegations were founded on nothing more than gossip, speculation and hearsay' (p. 6). She was well known to the participants of this study as she had previously held a senior nurse position within the same Area Health Service that employed the other nurses.

Information pertaining to Narissa is included in this research as each of the participants stated she was instrumental in their being labelled as whistleblowers nurses. Narissa, a senior nurse who publicly advocated against poor patient outcomes and unexpected patient deaths occurring in her own employing hospital, was instrumental in contacting each of the nurses for information about their own patient care concerns. She then offered those stories to the media without first seeking the nurses' advice or consent. The consequence of the unauthorised release of details to the media was unexpected misrepresentation and sensationalisation of the facts pertaining to each of the events as understood by the nurses. Because of her

eagerness to communicate and cooperate with the media she allowed herself to be erroneously portrayed as the chief of a group of vigilante whistleblower nurses.

The information available on the public domain incorrectly portrays Narissa as the voice of the whistleblower nurses in this study. Narissa, with her own agenda against the management of her own employing hospital, exposed 'a series of highly publicised allegations to the effect that senior officers from within a NSW Area Health Service deliberately covered-up improper practices and adverse incidents by destroying or concealing relevant evidence after they complained about such practices and incidents to State Minister for Health on 5 November 2002' (Independent Commission Against Corruption, 2005b, p. 6). A newspaper article describes Narissa as the 'leader' of the whistleblower nurses who famously claimed 'there had been a whole lot more patient deaths due to bad management at two NSW hospitals than the nineteen cases investigated by the Health Care Complaints Commission' (Jopson, 2003, p. 7).

Narissa declined to participate in this research. She stated she had been traumatised by the events and had been advised by her doctor that participation in this study was not in her best interests.

How important is truth telling to you?**Monique:**

That is why I became a nurse. I am not going to hide things under the carpet. We do make mistakes, but we can learn from those mistakes as well.

Meadhbh:

I am going to be very honest. I think that is the one thing that has got me through and made me hold my head up high is that I have always told the truth and have been found in the reports to have told the truth.

Violet:

I just did what I needed to do to assist in keeping it going and to tell the truth.

Yanaha:

They asked me questions and I told them the truth.

Simone:

I told the truth 100%. I never deviated from my story, I never changed my story. ICAC looked into everything I said ... they couldn't say anything but that I told the truth, because I did.

Kathrine:

I did my job. I reported the truth as it had been reported to me.

Truth telling is subjective, for individual reality equates to a perceived version of truth. Truth telling also has a dark side. It is commonly claimed to unburden one's self by telling the truth is cathartic and healing; Coyle and

Wright (1996) believe the action of expressing life experiences to others can be a 'therapeutic benefit' of participating in sensitive research (p. 58); however, the literature and this research do not support this supposition. For example, when witnesses were required to speak in the Rwandan Gacaca Courts, the effect of truth telling for these people did not result in lowered levels of psychological ill health as a result of unburdening themselves of their perceived truths. Nor has the prevalence of depression or post traumatic stress decreased for these witnesses over time (Brouneus, 2010).

The nurses in this study, as expected, advocated for their patients with their versions of the truth. This research would suggest the degree of sensitivity or the level of public attention generated by truth telling impacts considerably on the acceptability of the disclosure.

There is no clear description in the Australian literature as to what specifically defines a whistleblower nurse. It was pivotal to this study to understand the individual interpretations of this label by each of the participants in the context of working as a nurse in Australian society.

The aim of this chapter is to capture a snapshot of the professional and personal characteristics of each of the participants while discovering the events that led them to speak out publicly about the truth as they saw it. The decision to blow the whistle is underpinned by the professional mandate nurses will advocate for and protect their patients (Vaartio et al., 2006).

However honourable, the decision to speak out publicly is never undertaken lightly. The usual consequence for public declarations of poor patient care or adverse outcomes is public vilification, ostracism and marginalisation for the nurse (B. Berry, 2004; Faunce et al., 2004). Truth telling comes at a high price.

What did Nursing Mean to You Prior to the Whistleblowing Event?

Rationale for choosing nursing as a career

The catalysts which influenced the six participant's choice of nursing as a career was grounded in the desire to care (Warnock, 1998) for patients and their families, patient advocacy (Ahern & McDonald, 2002) and maternalism (Christensen & Hewitt-Taylor, 2006).

Monique:

I became a nurse ... I wanted to help people.

Yanaha:

I liked the idea of only having to look after one patient at one time and being able to actually focus your attention as part of the team on that patient's care - and giving that patient the best care possible.

Meadhbh:

I loved the work so much I would do it without being paid.

Violet:

Even though my love was Coronary Care, I loved the intensity of Intensive Care - with ventilators and multi-organ failure. I loved them

both and I thought it was the best possible world I could get having both.

Simone:

Absolute number one [priority] before a pan, before a pill, before a PhD ... the number one job of a nurse is patient advocacy. Your patient is your child.

Kathrine:

I am a nurturer, so nursing was a profession that appealed to me. Nursing to me is caring for others the way you would want your own family cared for. Nursing is also about honour, integrity and truth.

Each of the participants held the common view that nursing is a caring profession and that caring is inextricably linked to being a good nurse (Bowden, 2000; S. Lewis, 2003; Liaschenko, 1993; Tarlier, 2004). All of the participants entered the profession of nursing as teenagers based on the value they attached to the role of the nurse and their contribution to society.

Monique:

I am a patient and staff advocate who is a worker who takes pride in her work. It [honesty] is really, really important for the healing process and the grieving process, that families can see that we [nurses] did everything possible. I became a nurse 'cause I never had that with my father when he died.

Meadhbh:

I can remember from the early days training at St James in Dublin which was the school of hard knocks on the floor, saying that I loved

the work so much I would do it without being paid ... and that is something that stayed with me until I came and worked in NSW.

Violet:

Nursing to me wasn't just a job. It was really a passion for me I absolutely loved it. It was passion ... it was my contribution to the world.

Yanaha:

During my general training ... I didn't like nursing at all. In fact I hated it. I didn't like the Army style regimentation that we were subjected to. Then about half way through second year, when I was just about to throw it in, I did my first theatre term. This was where I belonged. I am comfortable and I like this.

Simone:

I am an enrolled nurse. I was hospital trained ... I did ten years of Oncology and Palliative Care [nursing] at a Sydney hospital. I had a very unique role. It was a very small unit ... I was very well educated. I used to give all of my own arterial chemotherapy, did all of my own cannulations, gave all my own oral and IM [intramuscular] medications ... everything ... except Schedule 8 drugs.

Kathrine:

I have always believed nursing to be a very honourable profession; however the expectation of subservience has for me been a lifelong challenge. Using science to help patients and their relatives has always appealed to me. I am a hypervigilant person who takes the responsibility of patient advocacy and patient safety very seriously. Nursing to me was never just a job. Until being labelled and punished as a whistleblower, it was the focus of my life.

What were the circumstances that led to raising issues of concern with your employer?

The participants of this study all appear to have a clear understanding of their role as professional nurses in terms of caring for the health and welfare of their patients (Benner, 2000; M. Johnstone, 1994; Tarlier, 2004) and the requirement for ethical decision-making to improve patient outcomes (Barry, 1988; Blackhall et al., 1995; Okasha, 2000; Vaartio et al., 2006). Individual experiences of poor patient care, issues of patient safety and adverse patient outcomes underpinned the concerns each of the nurses expressed for the welfare of their patients.

Simone:

I just thought I was being a patient advocate, identifying to colleagues that the practices that were going on were not in the best interest of the patient.

Yanaha:

This is a problem, patients are coming to harm, somebody needs to do something and if not me then who? Because no one else was doing anything.

Meadhbh:

It was quite clear that the case was going to go ahead had I not intervened ... and I mean maybe the kid would have been alright ... and maybe she wouldn't, and we are not there to take those kinds of risks.

Violet:

When you know that sort of stuff you have obligation ... not just an obligation, but morally you do the right thing.

Monique:

I became a nurse ... I wanted to help people.

Kathrine:

Nursing was my life. I am warrior born so it is in my nature to defend and protect. For me this is innate behaviour.

These examples of acceptance of the role of advocacy confirms these nurses would advocate for their patients when they experienced a departure from expected practice, voicing their concerns to their respective local management personnel (M. Johnstone, 1994).

Monique:

In Intensive Care, a patient had undergone an aorto-femoral bypass that had gone wrong. She was intubated, ventilated and sedated but she wasn't dying. This particular doctor ... who I had previously held suspicions about, went to the bed area and pulled the curtain around the woman. I was suspicious about what he was doin' at the head of the bed. I heard an alarm and I thought to myself 'Shit! What's going on?' I got up and saw bradycardia [slow heart rate on the monitor]. I went to resuscitate the patient when the doctor walks out and says, 'Don't worry' [dusting his hands together]. He walked away and didn't resuscitate this patient and I am going 'What just happened? What the fuck just happened?' I was left to prepare the body. It wasn't until I started getting rid of things around the bed area ... I found the empty syringe ... on a syringe pump. It was then that it dawned on me! He

must have caused her bradycardia by bolusing [deliberately administering a bolus dose] to the patient. That's why he walked away, because he knew I knew what he had done. We had another 'tubed' patient [patient waiting for a ventilator bed]. We had to either find another nurse or get rid of a patient! It was as simple as that!

Meadhbh:

During my first year of employment we had this patient for surgery on an elective abdominal aortic aneurysm. I was in charge that morning and I said to the surgeon concerned that one of the grafts was not available on site and that I would need to get one from St. Elsewhere. He said no he didn't need it, so we opened [the patient] and cross-clamped the aorta. That was when the surgeon said that he needed the particular graft that we didn't have. We ended up finding one and ordered a taxi to get there to pick it up. By the time the graft came and we put it in and unclamped the aorta, it was two hours. The time allowed for cross clamping is one hour. It took the patient about two months to die ... it was the most appalling death.

There was the scenario of the anaesthetic registrar who was on the phone discussing a fourteen-year-old boy with a history of a relative who, as a consequence of malignant hyperthermia, had died on the operating table ... this [discussion about the patient] was happening at our front door and I thought that this should not be happening. When the anaesthetic registrar came off the phone ... she got really annoyed with me ... The consultant anaesthetist was called in. The surgeon came and it was agreed that they would try to get the child to St Elsewhere. The surgeon rang, got a bed for surgery the next day and that was fine, so everybody was happy. The next thing I knew which was a couple of days later when a Human Resources person came

down to theatre and said to me that a complaint had been lodged about me and it was from the anaesthetic registrar. I got this three-page document of allegations against me and they stood me down.

Violet:

A patient came to Intensive Care from Delivery Suite. We were told she was an asthmatic in respiratory distress and that she was thirty-six weeks [pregnant]. Eventually the obstetric registrar came in. He wouldn't do the Caesar [caesarean section] because there was too much of a risk as the patient was too unstable. I remember the anaesthetic registrar yelling at him and me begging him, but he just wouldn't do it. So the anaesthetic registrar said 'Well we are going to have to ship her out then'. I left the obstetric registrar to phone Care Flight. Time went passed and I said to the anaesthetic registrar 'They [Care Flight] are not here yet. So off I went to ring them. The [Care Flight doctor's] response was 'Oh that ... No that doctor cancelled that, he said you and the other doctor were over reacting and that she was fine.' I said 'Oh my God, oh my God, [voice pleading] please just listen to me.' I heard him yell 'Gear up! Gear up! We're going! ... The patient was on the brink of death and so was the baby. The mother survived and the baby was born with zero Apgars [Numerical score indicating neonatal wellbeing at birth, 5 minutes and 10 minutes of age]. The mother survived with a baby that has profound cerebral palsy.

Yanaha:

One weekend, one of the surgeons turned up obviously affected by alcohol. An RN who was working with me said 'Dr X just pulled up and I went over to have a smoke with him and he's pissed! He was coming to do an appendix on a child. The RN went and said [to Dr X] 'Mate you're pissed!' and he said 'No I just had a glass of wine at lunch, but I

am not pissed. I'm fine. I'm fine to operate'. We got called back at about 10 o'clock at night for a torsion of a testicle. The Emergency Department nurse said to me 'Listen, I just watched him [Dr X] get out of his car and he is staggering drunk!' I said 'Oh my God, he was three sheets to the wind at lunch time imagine what he is going to be like at eleven o'clock at night!' The RN and I went round to the Emergency Department to find the anaesthetist, Doctor X and parents of the child. The RN and I said to the surgeon 'Now look! You can't even stand up straight. Why don't you do this case tomorrow morning? 'Why don't you put it on the end of that list tomorrow?' The anaesthetist said the kid wasn't fasted long enough and he said 'Alright, we'll do it tomorrow.

Meadhbh and I put together a conference called 'Learning to Love the Law'. There were a couple of doctors, a couple of nurses and the General Manager on the panel. I gave them all names and different roles [from the roles they normally undertook]. I sort of gave them the hierarchy of the chess set, i.e. the surgeon was Dr King, the anaesthetist was Dr Queen, the resident was Dr Knight and the role I assigned to the General Manager was that of the pawn. I called her Virginia Pawn (probably interpreted as Virginia Porn). I posed a scenario and I asked her 'Well what are you going to do Virginia? She was staring at the audience, I am not even sure if she was listening to me. I said 'Hallo ... hallo ... wakey, wakey are you with us Virginia ... you know Sister Pawn?' We never intended to make her look foolish. However, the feedback at the end of the day was that the audience thought that we made a fool of her and that she would be out to get us. I have no proof of this but...

Simone:

I was always a bit fan of the MET [Medical Emergency Team] system. As soon as a patient's blood pressure reaches a certain point, you can call this MET team and they will act before the patient is [mortally] compromised. I had a patient with terrible sleep apnoea. He was very obese ... We rang the doctor ... maybe three times. I said to him on the last occasion 'I am going to call a MET... He said 'Call a MET all you want cause I am the only doctor in the hospital and I ain't comin'! I am busy!' I tried everything ... felt so helpless, so I said 'Why not try the Laerdal bag over his face and just pretend?'... He breathed in ... after about a minute ... he calmed down and went to sleep. A couple of days later [sigh] at the disciplinary interview I was advised I had acted outside of my scope of practice.

I had this lady who had come into hospital dreadfully unwell ... I called a MET... The doctor came up from ICU and came charging into the room... then he goes [away]. I ring again and the MET team came back up. The doctor asked, 'What are you calling me again for? 'Because she has gotten worse'. So he goes up to the patient ... and said [in a very loud voice] 'You don't want to live do you? You don't want us to put a tube down your throat do you? You don't want us to be pumping on your chest and doing all that do you'? She says, 'Bloody oath I do'! He tried to coerce her to document herself as not for resuscitation. I said to him 'What are you doing'? He said 'I don't have a bed. What do you want me to do nurse? Pull one out of my arse'? I had called a MET three times by this stage and he said, 'Don't call me again'! I am watching her deteriorate and she said 'Please Simone ... don't let me die ... don't let me die'. I said [Simone burst into tears, sobbing now] 'I promise I won't'. And then I thought I can't do this anymore! I can't do it! I took the bed, I got to the lift and went

down to ICU; I pushed through the doors of ICU ... this nurse I saw with long hair [Violet]. Later I got a phone call from this nurse. 'Oh are the lady that brought down Mrs So and So?' I said 'Yeah'. She said 'Oh I am really sorry, but she's dead'. And I said 'No shit'!

Kathrine:

I was working as an After Hours Senior Nurse Manager at a New South Wales tertiary referral hospital. Monique [participant in this study] in her capacity as a highly experienced intensive care nurse reported to me that a senior Intensive Care Unit doctor had deliberately terminated the life of an elderly female postoperative patient by injecting her with the contents of a full syringe of narcotics. The rationale for this action was to 'free up' an otherwise unavailable ventilator bed for a young male who had undergone emergency surgery. In my role as the After Hours Senior Nurse Manager, I was obliged to report this sentinel event. This tragedy was made even more profound when the young male died on the operating table.

'Severe adverse patient outcomes that occur as a result of hospital systems failure are categorised as sentinel events' (Sharp, 2010, p. 1). All public hospitals are required to report information to NSW Health about sentinel events that have occurred. Mandatory reporting of events includes: procedures involving the wrong patient or body part; suicide of a patient in an inpatient unit; retained instruments or other material after surgery requiring re-operation or further surgical procedure; intravascular gas embolism resulting in death or neurological damage; haemolytic blood

transfusion reaction resulting from ABO incompatibility; medication error leading to the death of a patient reasonably believed to be due to incorrect administration of drugs; maternal death or serious morbidity associated with labour or delivery and an infant discharged to the wrong family (New South Wales Department of Health, 2005c, p. 13).

Studies have confirmed an epidemic of under-reported, preventable injuries to patients as a result of medical mismanagement (New South Wales Department of Health, 2005a). Policies from the NSW Health Department (2005a) place high priority on improving incident reporting 'as the first step in addressing patient injuries, and have called for translation of lessons from other high risk industries' (p. 4). In 2004, all Australian States and Territories agreed to contribute to a national data collection of sentinel events, a phrase defined by Wakefield (2007) as 'an unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof' (p. 24).

Meadhbh and Yanaha worked in operating theatre as Clinical Nurse Specialists; both submitted incident reports about poor performance and adverse patient care to their local departmental manager. However, the level of gravity they described in the reports regarding violation of procedural issues seemed unlikely to be taken seriously. They described their perception that during their 'Learning to Love the Law' seminar they had unwittingly embarrassed the General Manager, and as a result they

became targets. International studies confirm workplace psychological violence is more common than all other forms of violence and harassment (A. Yildirim & Yildirim, 2007; D. Yildirim, 2009), and that nurses experience higher levels of workplace violence than any other health care personnel (Ferrinho et al., 2003). D. Yildirim (2009) gives the most common types of bullying as attacks on professional ability, followed by attacks on personality. In the D. Yildirim study, forty-two percent of nurses surveyed stated they had experienced bullying from administrators. The survey also revealed administrators in high-level positions in nursing consider psychologically violent behaviours in the workplace to be approved techniques for imposing order within the hierarchical structure and in professional practice.

Violet experienced an adverse patient outcome which was reported to the management of her employing hospital. She was compelled to advocate for her patient, who she knew would die if she was not transferred to a facility that could offer a higher level of care than was currently available. Nurse advocates strive to support and protect their patients, yet they have considerable difficulty in addressing systemic problems, which include paternalistic doctors. Annas and Healey (1974) stated, 'the patient advocacy movement emerged from the broader social circumstances that led to a consumerist movement in health care' (p. 25). Mahlin (2010) argues, 'the problem with individual nurse advocacy is that it requires individuals,

themselves minimally powerful within the medical hierarchy, to fight on behalf of vulnerable patients' (p. 252). It seems nurses who advocate for their patients may experience pervasive fear and difficulties when dealing with doctors.

Simone, having worked in an extended (enrolled nurse) role in a previous position, considered that role extension, by virtue of experience, to be applicable in other clinical settings throughout her nursing career. She perceived entrenched poor nursing practice and poor Medical Emergency Team (MET) responses as justification for her to act maternalistically by willingly and knowingly acting outside of what would be considered a reasonable scope of practice for an enrolled nurse in the state of New South Wales. During the first interview, Simone described her patient as 'her child'.

Macciocchi et al. (2009) asserts health care professionals 'are ethically bound to let capable persons make decisions that we would not make, even if those decisions appear detrimental'; and adds that if the patient is compromised and the medical consequences are significant, maternalism (beneficence) may be justified (p. 73). However, if the patient is capable of rational decision-making and the medical corollaries are unknown or undetermined, ethical issues become more prominent. Ziegler (2007) comments that good faith has, by its nature, an objective and a subjective component; however, he rejects the idea that good faith could be exclusively subjective, and that the majority of people believe good faith must be

assessed by an objective standard. Simone perceived her actions towards her patients were in good faith: that is, she believed she exercised professional judgement and acted in their best interests.

Kathrine exercised her professional responsibility as on-duty manager of a tertiary referral hospital when the details of a suspicious death of a patient were reported to her by Monique. Following NSW Health protocol, this event was reported formally to the executive of her employing hospital.

The nurses in this study all perceived they had executed their professional obligation to provide a duty of care to their patients (New South Wales Department of Health, 2005b). Monique made the most serious allegation of all the whistleblower nurses when she reported to Kathrine – the on-duty senior nurse manager – her misgivings when a patient under her care died in suspicious circumstances. Meadhbh, Yanaha, Violet and Simone were involved in clinical situations whereby their patients were at risk due to clinical deterioration, lack of resources or perceived medical officer incompetence. Kathrine exercised her duty of care when she raised a critical incident report concerning Monique's allegation.

The NSW Department of Health protocol requires all on duty administrators to raise a critical incident report for any/all events which may attract media attention to the Area Health Service/NSW Health. It is not known if the critical incident report raised by Kathrine was notified to NSW Health. Only

after Narissa made the event public was it regarded and investigated as a sentinel event.

How did the information become public?

Narissa, Meadhbh, Violet, Yanaha and Simone, because of their meeting with the Minister for Health, were required to give evidence before the Legislative Council General Purpose Standing Committee inquiry into complaints handling within NSW Health. By virtue of their appearance at this inquiry, the media labelled them whistleblower nurses. The appearance of the nurses as a collegial, cooperative group of whistleblower nurses was a consistent theme portrayed in the media. Nothing, the participants declared, could have been further from the truth.

Monique:

I went to work at a peripheral Sydney Hospital. When I was checkin' the drugs out one day, someone said to me 'Well how was it for you?' And I thought, 'What the fuck are you talking about?' She told me that my name was in the paper and when I got the article, there it was! I had been named!

Meadhbh:

It was Narissa in fact who contacted Yanaha and me to talk about a visit to the NSW Minister for Health. I had met Narissa while I was working at my hospital and she was having issues. This was the point where Narissa had told us about her brother ... the solicitor. She wanted us to give him a thousand [dollars] to represent us. At the meeting, I spoke first because I was seated next to the Health Minister

and explained my situation. I complained about the care patients were getting and the practices in the hospital and how ultimately, I lost my job as a consequence [of voicing complaints]. I found Narissa to be ... well, I thought she was mad. I honestly thought she was mad.

Violet:

I joined up with Narissa, because she asked me to. Narissa was the one who led the way. Narissa would say to me ... and only later I found out that she was lying ... but lying for a good reason... She would either lie to me and say 'Oh it's [the meeting] is not on today, its next week' or she would say 'Oh no you are not allowed to come.' I didn't attend the initial meeting with the Minister for Health. Narissa said that I was a mess and that I couldn't come. I wrote a statement ... they were a strong united front and I definitely wouldn't have been an asset at all. Even with the statement that I wrote ... well ... I actually couldn't write it ... Narissa came over and I spoke and she wrote...

Yanaha:

Meadhbh and I had lost our jobs. I got a phone call from Simone who was still at that time working at the hospital where I had been previously employed. The next thing, Narissa [who had been Simone's boss] rang me to say 'I've got an appointment with the Minister for Health'. So Meadhbh and I, Simone and her [Narissa's] brother all turned up on this fateful day to see the Minister for Health. He listened to us and he seemed concerned. [He said] 'We are going to have an inquiry into this!' Narissa kept saying, 'You know they are killing people! They are killing people! You have to do something! And he said 'Yes I am. I am going to have an Inquiry'. [Narissa] 'They're killing people! They're killing people!' The Minister for Health in a loud voice

said 'Look! I've told you already three times for God's sake! I am taking this seriously! I am going to have an Inquiry!' It wasn't very long before I received phone calls from somebody from NSW Health. Their recommendation was that the HCCC undertake an Inquiry into the hospital that had employed me ... That was when we started getting the major radio presenter involved.

Simone:

I spoke to a senior journalist from a major Sydney newspaper. Narissa said, 'There is this reporter and he is one hundred percent confidential. You can trust him. He has had a lot to do with whistleblower nurses.' Now there was never, ever any hint that we would take this public. There was no discussion, no big meetings until the day at the Minister for Health's office. I had never met Meadhbh or Yanaha. I had seen Violet once before when I crashed through the ICU door.

Kathrine:

I left my position as a senior nurse manager considerably damaged by the experience. I was coming home from working an Agency night shift when I heard Narissa talking on air with a major radio personality. She was relaying the details of the termination of the life of the patient at the hospital where I had been previously employed. Her account of the event was not only misleading, it was factually incorrect. Never before in my thirty-year career as a nurse had I ever entertained the idea of speaking out to the media. But this was different! The nurse in me became enraged that more lies were being told and that Narissa was using this event to promote her own agenda about poor patient care and adverse patient outcomes. On impulse I immediately contacted the radio station, told them who I was and

declared what had really happened ... a media storm ensued, my career was over and the rest as they say is history.

The decision by a nurse to speak out publicly about an adverse patient outcome or an unexpected death is reflected in the historical evolution of nursing ethics. Walker (1900) stated, 'future members of our profession may be, above all women, high-minded, strong hearted, striving not only to gain honour in their own individual work, but to heartily aid in establishing and maintaining a code of honour, in elevating the standards of nursing education and in promoting the usefulness and honour of the nursing profession' (p. 207).

When Kathrine heard Narissa 'on air,' providing a distorted account of a patient's death she and Monique were familiar with, she considered it imperative that an accurate account be made. Kathrine describes being compelled even after the death of this patient to advocate for the truth, as she subscribes to the philosophy, 'no amount of ability which a nurse may display in other directions can possibly be accepted as a substitute for right conduct' (Aikens, 1937, p. 39).

Kathrine became labelled a whistleblower because of an impulse. In truth, the prospect of consequences were not even considered. If she was correcting an untruth, why would there be repercussions? In that instant, it was her need to set the record straight and not mislead the dead woman's

family or the public into believing Narissa's exaggerated and factually incorrect account of Monique's original report. It was from this declaration a major radio personality requested an interview. Kathrine spoke on air to the major radio personality, and a furore ensued. Ironically, this interview provided the first corroborating 'evidence' to the media; evidence that appeared to support Narissa's accounts.

Monique, as the nurse who reported the alleged termination of the patient in Intensive Care, was located, and interviewed by Homicide detectives and ICAC. Despite never attending any public hearings she was identified by, and exposed in, the media. All the nurses with the exception of Monique (who was named but never photographed) had some degree of public exposure. The naming of Monique as a whistleblower nurse by the media only occurred after the incident was made public by Kathrine.

Moral responsibility underpinned the decision of each of the nurses to speak out about their patient care concerns. While one might argue this is an expected virtue of a professional nurse, it places the nurse at significant risk. Why should nurses be expected to bear the weight of patient advocacy if that action poses potential harm to them? Marlin argues,

Moral virtue alone is rarely sufficient to compel actions that could harm one's self interest ... For nurse advocacy to be effective, nurses must not fear personal repercussions, otherwise to advocate constantly

means that they must continually place themselves at risk, which is unjustifiable when carrying out a professional duty. (2010, p. 250)

The thread that linked Violet, Yanaha, Meadhbh, Simone and Kathrine as whistleblower nurses was twofold. First, with the exception of Monique, the nurses were all employed within two peripheral public hospitals (within a common wider Area Health Service) in NSW. Second, Narissa, in her capacity as a senior nurse (also employed by one of the peripheral hospitals), was acquainted with all the nurses with the exception of Monique, who worked in a different hospital.

As part of her agenda to prove her allegations about wrongful treatments and poor patient outcomes, Narissa co-opted the voices of other nurses whom she knew had concerns about patient care and advocacy, as a means of adding credibility to her allegations. Monique refused to speak with the media, and was the only nurse never to speak out publicly. She was identified by Kathrine when she was required to give evidence to Homicide detectives and ICAC.

If you had the opportunity to go back to a time prior to the events that happened to you, would you make the same choices?

The participants of this study readily admit they spoke out about perceived adverse patient outcomes and poor clinical practice because, as professional nurses, they felt ethically compelled to apply the principle of beneficence and advocate for their patients (Macciocchi et al., 2009). The do-the-right-thing

ethic also played a considerable part in the nurses' decisions to speak out publicly (De Maria & Jan, 1997). Professional morality underpinned each of the nurses' decisions and actions in their attempts to notify authorities of adverse patient outcomes, poor clinician performance and deviation from accepted standards of clinical practice, when they perceived local management authorities failed to act upon their concerns.

Monique:

Bloody oath I would. That is why I became a nurse. I am not going to hide things under the carpet. We do make mistakes, but we can learn from those mistakes as well. I would do it again. I wouldn't not, say anything because I would not let that bastard [the ICU doctor] get away with that. I have to live with my conscience. On my deathbed, I can say to myself 'Well Monique you tried. At least you tried. You didn't pretend it didn't happen. I am a worker ... I won't put those blinkers on. I won't do it. I may as well get out of nursing.

Meadhbh:

Well that is a question that I ask myself over and over because ... what happened had a huge impact upon my life. So much has changed in my life. The bottom line is I never saw myself as a whistleblower. I was somebody who was doing what I believed to be the right thing. I know that some people used this opportunity to damage me and I think ... in all ... I don't think they expected the outcome to be as serious [as it turned out to be]. I don't believe they wanted me to be this destroyed, but I know that they wanted to shut me up. In answer to this question and this is the interesting thing, this is a terrible thing that has happened. But, I couldn't not do it, because it is how I ... it's

how I look after my patients ... I say no, this is wrong. It is also the personality I have too in that I am not afraid to speak up.

Violet:

Was it worth it – no, because nothing really changed. But would I do it again? Yes. When you know that sort of stuff you have not just an obligation, but a moral obligation ... morally you must do the right thing. You want to do the right thing. So I would do it again, but I would just be more ... if I had the knowledge I have now, I would not be so naïve and I would know to write down everything ... to have collected more information like Narissa did ... yeah that is the only thing I would do differently.

Yanaha:

Well it wasn't a choice really. It wasn't something that I made a conscious choice about. Patients were coming to harm, somebody needed to do something and if not me, then who? Because one else was doing anything. That's what I don't agree with. I can't stand people who just turn a blind eye. I can't stand to do it myself ... I can't do it. It is not a choice; it is just something that you feel is right. I was just being a nurse as far as I was concerned ... I was just doing my job! So I would have to say I would do the same thing because it is not a choice.

Simone:

Every time! Every single time! You could ask me that in ten years or in twenty years or in one hundred years and it is never going to change! But I hate to say this, it has changed me. I have seen things since that I haven't reported. If that had happened before, I would have reported it. But this has taught me you can't change everyone's practice and that if you practise the same way consistently every time, often the

people around you will change their practice because they realise that they can do it better.

Kathrine:

I did my job to the best of my ability and it was to my absolute detriment. I exposed the truth about the patient who was allegedly 'terminated' by an ICU doctor; a truth that would otherwise not have come to light. Would I make the same choices again ... for the most part I would say yes ... however when my family struggles to make ends meet because I no longer earn the type of income I used to earn, and when the fear returns and consumes me, I struggle with it. But after everything that has come to pass, I feel no guilt. I did my job as a nurse and I can sleep at night. I know I told the truth ... for what that is worth in the face of a ruined career and an acquired life-long acute anxiety disorder. Would I speak out again ... God help me, yes.

Gibson and Heartfield (2003) described professional morality as 'answering a patient's call for care, while attempting to alleviate suffering and enhancing well being, to reflect the core of a nurses' professional responsibility' (p. 18). Each of the nurses was compelled to speak out publicly due to her perceived professional responsibilities to her patients by enactment of the principles of patient advocacy (Holly, 1993), individual professional belief systems (Ahern & McDonald, 2002), responsive nurse patient relationships influencing clinical outcomes (Diekemper, SmithBattle, & Drake, 1999; Tarlier, Johnson, & Whyte, 2003) and maternalism (Holden, 1996).

The participants of this study, despite being labelled as whistleblowers all declared they would speak out again if they perceived any of their patients were in danger of harm. The nurses describe their role in protection of patients by speaking out publicly as 'just being a nurse ... a matter of consciousness and ... an act of advocacy and moral obligation'.

Conclusion

This chapter details some of the patient care experiences of six nurses who worked in public hospitals in NSW. The participants revealed they chose nursing as a career because of the importance they appointed to the concept of caring and advocacy for patients. The events that led each of the nurses to speak out publicly were grounded in patient advocacy, fuelled by the understanding that nurses have a responsibility to protect their patients from harm. Maternalism was an obvious motivating factor for at least one of the participants. It has been revealed that none of the six nurses in this study sees herself as a whistleblower, as none actually spoke out publicly before their information was released by Narissa. Rather, each spoke out because of expected professional conduct, good faith, beneficence, moral responsibility and the Australian cultural ethic 'to do the right thing'.

The media portrayal of the participants of this study as a group of vigilante whistleblower nurses was an illusion, created to sensationalise the nurse's allegations and detract from the true purpose of the telling of their truths. The nurses' advocacy concerns were harvested by Narissa, who without their

consent released their stories to the media. This action presented Narissa as the mouthpiece for the nurses (an assumption she did nothing to contradict), and caused her to be labelled by the media as the chief whistleblower nurse.

Chapter 5 will explore the consequences imposed upon each of the nurses in this study for their role as whistleblower nurses within the NSW public health system.

Chapter 5:

The Consequences of Advocacy

Every person has free choice. Free to obey or disobey the Natural Laws. Your choice determines the consequences. Nobody ever did, or ever will, escape the consequences of his choices.

–Alfred A. Montapert

Miceli and Near (1992) and Rothschild and Miethe (1999) state that nearly all occasions of whistleblowing relate to work and organisations. The first qualitative study of retaliation against whistleblowers was by Parmelee, Near and Jenson (1982). The aim of the study was to measure the organisational breadth of retaliation to acts of whistleblowing by counting the number or types of identified episodes of retaliation that had either been threatened or had occurred. This study paved the way for other researchers to consider occasions of retaliation or threats as yardsticks of the degree of retaliation experienced by the population under study (Miceli & Near, 1984, 1994; Near & Miceli, 1986; Perry, 1993).

Monin, Sawyer and Marquez (2008) in their study involving college students conclude that reaction to whistleblowers falls into three categories. First, uninvolved observers will be inspired. Second, co-workers will be hostile as their own obedient behaviour towards wrongdoing or silence may be called into question. Third, co-workers not directly involved will be passive. A study conducted by Shahinpoor and Matt (2007) reveals bosses continue to act

like feudal lords, obsessed with their own order. It also revealed that anti-whistleblower behaviour is promoted in the form of rewards for conformity, obedience, loyalty towards bosses, and avoidance of blame. To question is seen to be insubordinate and worthy of hostile reaction. From this perspective, organisational behaviour is 'the snapping beast of its masters'. Yeargain and Kessler (2010) state, 'it is human nature to punish those who do not follow the crowd', and add 'speaking up against others is violating a rule – a rule which has been implanted early in our psyche' (p. 90).

This research, and the literature reviewed in Chapter 2, confirms that reprisals and sanctions are commonplace for nurses who speak out publicly about patient advocacy and patient safety concerns (Deans, 2004; Einarsen, 2000; C. Holmes, 2006; D. Jackson et al., 2002; J. Madison & Minichiello, 2000; Salin, 2003).

Meadhbh:

I do blame the break-up of my marriage [on the whistleblowing event] ... I became somebody who obsessed, because there was nothing else that could be talked about other than what was happening at the hospital.

Simone:

I can't communicate ... it has destroyed our marriage.

Violet:

I lost my job at the hospital and I am no longer a nurse. I hate life ... I hate life. I resent the fact that I have to live life!

Yanaha:

I started to drink ... too much ... um ... and I mean that's five ... six years ago and it has taken me all that time to make a conscious effort that I wasn't going to become an alcoholic ... I could have ... easily...

Monique:

I ended up having a heart attack [and bypass surgery]. Yeah, eating disorders you name it ... lose weight, put weight on ... sleeping ... sleeping problems.

Kathrine:

I now understand post traumatic stress syndrome and all of its demons. I understand the meaning of fear. Alcohol, food, anxiety, insomnia and crippling terror became my constant companions. I didn't think I would survive ... I considered ending my own life.

What (if any) were the physical, psychological, social or professional effects you perceive to have occurred to you as a result of being a whistleblower?

While the issues of patient advocacy and patient safety were raised within the professional work environment, the responses were directed not towards the professional nurse, but towards the human person. Psychological terror (Leymann, 1996) and loss of career impacts severely not only upon the individual's economic status but perhaps more importantly, on the person's physical and emotional status (Bjorkqvist, 2000; Cowie et al., 2002; Einarsen, 2000; Fox & Stallworth, 2003), leaving them vulnerable to a lifetime of issues related to substance abuse and addictive behaviours.

Monique:

Allegations were made against my reputation that I was a drug addict. The Director of Nursing ... said she believed the allegations were true ... she had reported me to the Nurses and Midwives Registration Board. ... Over a period of months ... the waiting ... not knowing if I had a job ... horrible. The Nurses and Midwives Board notified me by mail that the allegations were unfounded and there were no restrictions put on me as a nurse. After I was named in the newspaper article, I took annual leave. Post traumatic stress syndrome! Fucking oath Post Traumatic Stress Syndrome and no it doesn't go away! That fear factor is there! And it's not far away. It's like 'Oh fuck!' Every so often, it just ignites. It just takes one situation and you think 'Fuck here I am again. In 2004, I had a massive infarct [heart attack] ... and bypass surgery.

Meadhbh:

I think primarily the first thing was not sleeping and starting to drink heavily, palpitating, being totally insecure, taking up compulsive eating. Having gone through the compulsive phase to eat, to night sweats, to waking up in a panic, to being somewhere and seeing somebody I perceived to be the General Manager of my hospital which absolutely devastated me to the point where I would have to go home. I stopped going out totally as a result of that. When I had to go to doctor's appointments, I would have to be escorted, because I could not physically do that myself. I stopped looking after the house, didn't cook, didn't shower! [Emphasis], lost absolute interest in any kind of self-maintenance. Around that time my husband left me. I had gone from a size 8 to a size 16 and now I am now to nearly a size 6. I do blame the events at that hospital for the breakup of my marriage.

Violet:

I couldn't think. I didn't want to talk. I couldn't think straight. While being a nurse, I picked up staph [a staphylococcus infection]. It never affected me, but with all the stress ... boils ... the pain was excruciating. My friends were basically with me every day because at one point I was moribund. It took its toll in the end. I exhausted a couple of friends. At first ... it was all like a fantasy ... I resented the fact that I couldn't do it [commit suicide]. I couldn't ... because I had my son. But there was resentment there because I had to be there for him ... because if I didn't have him I would be able to get out of this. I hate life ... I hate life. I resent the fact that I have to live life. I wish I wasn't here, but I have to be here for my son. I would give up tomorrow if I could.

Yanaha:

Initially I just dropped 10 kilos, couldn't eat ... I shook ... I think part of the weight loss was that I was shaking constantly, my metabolism was in overdrive. That was the most noticeable physical thing. I started to drink ... too much ... [sad laugh]. I was at a point back in 2003 when I contemplated jumping from a building ... a very tall building ... but I couldn't get the window open [sad chuckle]. I don't think I really wanted to die ... I just wanted to escape. But yes, psychologically I was as low I have been ... as low as I would ever, ever want to get. I never want to get to that point again where I felt hopeless.

Simone:

The only way I kept going for four years was ... just to maintain the rage, otherwise I would never see it through. I have always responded to stress in a way that is probably not good for my body – overeating,

overindulging. In my marriage ... a bitterness ... ultimately took my life in a different direction. And I changed; I was not the same person. I just forgot how to communicate. I can't communicate ... it has destroyed our marriage. The anxiety at night would be overwhelming ... I would have these panic attacks I never used to drink alcohol, now I drink alcohol. In the first two years, I started gambling. I was going on poker machines and I would be there almost when it [the club] opened, just sitting there pressing the button. Just pushing it ... a thousand dollars, two thousand dollars, it wouldn't make any difference...

Kathrine:

I was severely affected both psychologically and physically by the events at the hospital that employed me as a senior nurse manager. The rage I felt about how I was treated changed me irrevocably; altering my respect for the profession of nursing and the faith I hold for the people I work with. It became obvious; my career at this hospital was over. Little did I realise that reality would be extended to every public hospital in New South Wales for the rest of my nursing career. I now understand post traumatic stress syndrome. I didn't think I would survive. But I knew the loss of my life would devastate my husband and my children. I couldn't inflict that pain on them ... but some days ... I have been advised by my current employer that because of my perceived whistleblower status, NSW Health will never again employ me in a senior capacity. They have remained true to their word. Today, I have an acute anxiety disorder that will be life-long. In the face of our lost investment portfolio that would have seen my husband and I comfortably retired at age 55. I have more than doubled the mortgage, and dread the prospect of working well into my seventies. I have learned to fear the fear.

The participants of this study all described significant changes in their behaviours, habits, feelings and relationships; all of these were attributed to speaking out publicly. Monique sustained a heart attack which required open heart surgery. She believes the stress of not being believed by her managers and the subsequent labelling as a drug-affected nurse were contributory factors in her sudden onset of cardiac ill-health. It is her belief that she now suffers from post traumatic stress syndrome, which is unpredictable and recurring.

Meadhbh and Yanaha as proactive Clinical Nurse Specialist (CNS) theatre nurses saw themselves as staunch patient advocates. They raised concerns about patient care and procedural issues with the local management. After conducting a role play in a seminar, they believed they had inadvertently but very publicly embarrassed the General Manager of their hospital. It was soon after the seminar that both nurses were investigated about alleged complaints about their personal and professional behaviour. The General Manager may have been, as described by Ashforth (1997), 'someone who uses their power and authority oppressively, capriciously and perhaps vindictively' (p. 126). Both nurses described the absence of information about the nature of the complaints that had been brought against them. Both nurses were dismissed and escorted off the premises.

Today, Meadhbh and Yanaha still have not been provided with the evidence or the reason why they lost their jobs. ICAC was critical of the investigation

by the HCCC of both nurses as the allegations were unfounded, concluding they had been denied procedural fairness, that the investigation of allegations made about them was flawed and the action taken against them was 'heavy handed and confrontational and did not consider all the relevant factors including subjective mitigation factors. It is even questionable whether there was sufficient basis to proceed to disciplinary actions' (Health Care Complaints Commission, 2003, p. 177).

The General Manager (a registered nurse herself) of the hospital that employed Meadhbh and Yanaha had, before her appointment, held a senior post within the industrial body representing nurses throughout the state of New South Wales. The whistleblower nurses alleged their complaints were not addressed adequately because of suspected cronyism between the General Manager and the union.

Meadhbh:

When I got my payout, my long service leave was withheld ... they [the industrial body] already knew [that the monies were being withheld] ... because I'd upset the General Manager!

Yanaha:

Yes I did involve the nurses association. They were my first port of call! Number one! Ten minutes after I had been suspended! Their response initially was ... no response at all ... they weren't there ... they weren't there on the other end of the phone!

Simone:

You [the industrial body] are supposed to be there for nurses and you are not there, you are there to advance your own political career ... the point of view of what the industrial body is supposed to represent is that of nurses! I was being victimised. I was a member of the nurses union! [emphasis] I AM A NURSE! I have been a member of the union for a very long time ... some of the incidents they were complaining about went back to prior to when I joined the association, he [the General Secretary] made this big bleat to cover his own arse.

Violet:

I was a member. They didn't want anything to do with us. I didn't contact them because I knew they didn't want anything to do with us. They are friends of you know, the Labor party and so yeah no definitely no support.

Monique:

I had no involvement.

Kathrine:

I didn't contact them because from previous experience I knew if the issue at hand was likely to be public or messy, the industrial body will not support the member. Aside from this fact, at one of the inquiries I attended, the General Secretary of the industrial body was asked to declare any relationship he may have had with the [then] Minister for Health. He begrudgingly admitted he had attended social barbeques and had made a significant monetary contribution to the Labor Party's election campaign.

ICAC (2005a) interviewed the General Secretary of the industrial body in relation to this matter. The General Secretary stated, 'the New South Wales Nurses Association had decided not to take action in the Industrial Relations Commission (IRC) on behalf of Meadhbh and Yanaha, based on legal advice it received to the effect that there was not a high likelihood of obtaining an order for them to be reinstated' (p. 55). The nurses alleged their issues also were not adequately addressed because of an existing relationship between the Minister for Health (of an incumbent Labor state government) and the General Manager of their employing public hospital. ICAC confirmed the Minister for Health 'knew' the General Manager (Independent Commission Against Corruption, 2005b, p. 26). The nurses also alleged the General Manager's membership to the Australian Labor Party (ALP) was a barrier to a transparent investigation of their claims about patient safety and patient care issues. The ICAC (Independent Commission Against Corruption, 2005b) confirmed the General Manager conceded she was a member of the ALP for a period of approximately eighteen months in the mid 1990s but had not been a member since. The Minister for Health stated he had not been aware the General Manager had been a member of the Australian Labor Party until the investigations began in late 2003 (Independent Commission Against Corruption, 2005a). The complex relationships at the higher political, organisational and professional health care levels were viewed by the

participants as counter-productive and unlikely to foster any objective assessment and change.

Rowell (2005) estimates eighty-one percent of bullies are bosses, and asserts bullying among health care workers is increasing: 'These bullies through dominance of others devalue and demean the strengths, abilities, competency, intelligence and integrity of other workers' (pp. 377-378). In the workplace, an abuser who holds a position of authority often uses it to exaggerate or fabricate weaknesses in others.

The perceived abuse of power by the General Manager is, as Khalil (2009) describes it, an example of vertical violence. Ishmael (1999) argues that psychological violence is the most demoralising type that workers can impose on others (p. 58). It is conceivable the General Manager considered herself to have been publicly humiliated by Yanaha and Meadhbh and sought to make an example of them. Ishmael confirms public humiliation is a form of psychological violence that results in emotional distress or discomfort for another person or colleague (p. 60).

Hutchinson, Vickers, D. Jackson and Wilkes (2006) and M. Lewis (2006) further argue that hierarchical systems in nursing encourage the phenomenon of horizontal violence, accepting abuse of power as a privilege of position. The chairperson of the General Purpose Standing Committee Inquiry into complaints handling within NSW Health described 'the old girls

network' as a 'political network of senior female administrators running the NSW health system which included the former General Manager' of the hospital named in the Inquiry (Pollard, 2004, p. 19).

Meadhbh and Yanaha experienced third degree mobbing (Leymann, 2006) in the forms of psychological violence and relational aggression (Dellasega, 2009) displayed by the General Manager. The nurses described a myriad of physical and psychological consequences:

Meadhbh:

I started drinking heavily, being totally insecure...

Yanaha:

I couldn't eat ... I started to drink ... I was as low psychologically as I ever want to be again...

They considered these behaviours the direct results of being dismissed from their positions as nurses.

Violet experienced adverse patient outcomes in her workplace, too. 'I was moribund...' It was her direct association with Narissa that caused her to be labelled as a whistleblower nurse; Violet never spoke out publicly. When she appeared with the other nurses to give evidence at various government inquiries, she was photographed by the media and labelled a whistleblower nurse. Her close association with Narissa, she later realised, was detrimental to her emotional wellbeing and self confidence. Violet stated 'She [Narissa)

would either lie to me and say 'Oh it's (the meeting) is not on today, its next week' or she would say 'Oh no you are not allowed to come' or something like that because I would say 'What do I have to do this week?' I was pretty much in a daze. Her evidence regarding adverse patient outcomes was manipulated by Narissa, who also misled her about scheduled meeting times and dates to ensure Violet could not attend.

Violet falls into the category described by (Leymann, 2006) as third degree mobbing; ten percent of the workers involved in his study considered suicide as a result of the effects of workplace harassment. Violet's suicidal desire is not solely the effect of her experience of victimisation by her employer, but includes *her* reality of the profession of nursing and her perception that everything she believed in was shattered (Rosen et al., 2007): 'My psych [psychiatrist] said that was the day that I stopped believing in people. And I believe that to be true'.

Simone, although well intentioned, became the object of criticism and bullying when she insisted on summoning the Medical Emergency Team to assist patients under her care. Professionally she described being ostracised and marginalised, which, according to Rosen, Katz and Morahan (2007), is typical of workplace bullying. Her admission of overindulgence in food, gambling and alcohol can be interpreted, according to Raskaukas and Stoltz (2004), as a profound reaction to relational aggression, a type of workplace bullying which refers to the use of psychological and social behaviours rather

than physical violence or direct harm towards others. These behaviours are typical of second degree mobbing (Leymann, 1990).

Simone attributes her loss of ability to communicate with her husband and the subsequent breakdown of her marriage to her experience of workplace bullying. Leymann (1990) notes when victims are mobbed, their sadness and distress causes a negative spill-over effect onto the bullied person's families. As she continued to behave in what she considered her advocatory role for her patients, the level of aggression and bullying escalated from second degree to third degree mobbing.

Monique believes she has acquired post traumatic stress syndrome because of the stress she experienced, first when she reported the death of the patient under suspicious circumstances and then from the retaliatory tactics of her employing hospital. She attributes her heart attack to these stresses. The fear described in Lehmann's (2006) work seems to be manifested in Monique's responses. Her heart attack and terror are examples of extreme level three on the mobbing scale

Kathrine has acute anxiety disorder that is reactive to stressors in her work environment, which intermittently renders her overwhelmed by a sense of all-pervasive fear. She knows, despite her experience and significant academic qualifications, she will be excluded from career progress for the rest of her working life if she continues to work in the public health system

in NSW. Aquino and Thau (2009) explain workplace victimisation occurs when acts of aggression are perpetrated by one or more members of an organisation on another member. By being denied career progression, Kathrine has been robbed of a sense of belonging within the nursing profession and the notion that she is a worthy individual (Stevens & Fiske, 1995). As a consequence of the whistleblowing event, she no longer believes she has the ability to predict or, cognitively control her work environment, or trust others with whom she works. Leymann (2006) describes typical reactions to the most severe form of bullying, third degree mobbing, as the abuse of food and alcohol, paralysing, acute anxiety disorder, chronic extreme fear and mistrust of the workplace: all symptoms experienced by Kathrine.

As a direct result of being labelled as whistleblower nurses, all the participants of this study experienced acute psychological and physical stresses which precipitated a myriad of negative coping mechanisms such as overindulgence of alcohol, food and gambling. Monique in particular suffered greatly, with the stress of the allegations against her inducing a heart attack. Violet, because of the stress of events, became immunosuppressed and suffered staphylococcus abscesses. Career loss and loss of professional reputation were common among this research group. Career opportunities were limited or withdrawn, and the anticipated length of a life-long career reduced because of financial losses. All the participants considered suicide.

Violet continues to have suicidal thoughts, and hates her life after the whistleblowing event.

The Role of the Nursing Industrial Representative in your Whistleblowing Experience

The industrial body representing nurses in New South Wales is the registered union for nurses in both the public and private health care systems in New South Wales that represents the interests of its member nurses, who are employed under various awards and workplace agreements.

The General Secretary of the industrial body was criticised by the participants of this study for a perceived lack of support for them when they were accused of being whistleblower nurses. The participants believe the politics of whistleblowing is contrary to Labor Party policies. Also, the perception that the industrial body shared a political alliance with the Labor party caused the nurses to believe they would not be supported by the union. This point was confirmed in a statement of the General Secretary, that 'when the allegations covered in the ICAC Inquiry were first aired, the NSWNA took a cautious position. We recognised that the appropriate bodies such as the HCCC have a legitimate role to investigate such claims' (B. Holmes, 2005b, p. 2).

Monique:

I had no contact with the industrial body.

Meadhbh:

I would like to have believed that even with the management system that I had complained of, that I would have had a union that was interested in me as a paid up member. Unfortunately, that was not the case. Because ... from what I have seen ... between my hospital and the union, there is an incestuous relationship. And where you have that, there is no fairness for a member. I wanted my long service leave, and this was done through the union ... we were offered money to go away and not to disclose the events that occurred. We didn't ask for that ... however they put it into a plan and did it ... They didn't want the General Manager upset.

Violet:

I was a member. They didn't want anything to do with us [whistleblower nurses].

Yanaha:

Yes I did involve the industrial body. I made contact with them and advised I have just been suspended from my job! I mean who the hell has ever heard of a nurse being suspended from her job unless you are a drug addict or felon you know? I couldn't believe it ... so I was hysterical.

Simone:

I was in the union for a really long time ... I left nursing due to ill health. I resigned ... my health improved ... I went back to nursing part time and I didn't rejoin the union because I was working here and there. I started working ... and joined back into the union. I didn't hear anything from them ... I mean they were taking my money ... I went to the fact finding. I thought I was fine. They [the interview

team] never gave any indication that anything was wrong. Then I got this letter to say I had to have a disciplinary interview. I rang the nurses association and they said ... 'No sorry we won't be able to do that' [represent her concerns]. I said, 'What do you mean?' They said, 'Well if you took it upon yourself to go to the fact finding interview without us, we can't come and represent you at the disciplinary hearing'. No! They flatly refused to come. They said that [this issue central to the disciplinary hearing] had predated ... It appeared to them that I had joined at the time that this must have been going on. But I hadn't, I joined before, when I got the job.

Kathrine:

Although I was a financial member of the industrial body, at no stage during the lead-up to or during my eventual expulsion from the hospital that employed me did I make contact with them. The reasons I did not raise my concerns were two-fold. Firstly, because of past experience, it was apparent the philosophy of the industrial body was that if they can't win it, they won't have anything to do with it. Secondly I was well aware of the political alignment of the union association and the Labor Party.

It seems financial membership to the industrial body does not, as attested to by Simone's experience, entitle nurses to automatic, open access to advice about contentious nursing issues. The propensity to be cautious (B. Holmes, 2005b) in the offer of support for the whistleblower nurses was interpreted by the participants of this study as an abdication of responsibility by their industrial representative, preferring government bodies such as the HCCC

(Health Care Complaints Commission) to deal with nurses who might attract political notice and media attention.

A perceived relationship between the industrial body and the hospital General Manager was an issue for three of the participants of this study. In a press release made by the General Secretary, it was stated, 'the ICAC inquiry found that three nurses were subjected to disciplinary action that was so flawed and unfair that the nurses were entirely justified in suspecting they were being victimised' (B. Holmes, 2005a, p. 1). At the Annual Delegates Conference (2007) the Guidelines for Whistleblowing and Nursing was endorsed, with the recognition of:

Payback, loss of opportunity for advancement, harassment, victimisation and disciplinary action or dismissal as appropriate for members to seek advice from the NSWNA. It recommended, where appropriate, referral of nurses with serious health care issues to external agencies such as the NSW Ombudsman, ICAC or the Auditor General in cases of serious or substantial maladministration of public funds ... The organisation also has obligations under common law and occupational health and safety legislation to make sure that whistleblowers do not suffer as a result of coming forward. (New South Wales Nurses Association, 2007, p. 20).

This research finds these guidelines to be unrealistic, inadequate and in no way protective of nurses who speak out publicly. The evidence in this research confirms whistleblowers receive no protection under common law; nor are they protected from workplace harm under current occupational and

health and safety legislation. These guidelines provide little more than lip service to the protection of nurses who are highly vulnerable when they speak out to advocate for their patients.

Monique, Violet and Kathrine decided not to involve the industrial body in their allegations of bullying and harassment because they believed that if the situation was politically complex the industrial body would not adequately represent them. All the participants of this study recognised the existence of cronyism between the industrial body and the incumbent Labor government of New South Wales:

Violet:

They [the industrial body] were intertwined ... with the Labor party and so definitely no support.

Kathrine:

The relationship between the industrial body and the Labor Party was obvious to me. Given the allegations I made, I was not going to receive appropriate advice, because of the nature of my allegations and the effect they potentially would have upon the reputation of NSW Health and the NSW Health Minister.

Meadhbh and Simone felt they received poor advice and poor representation from the industrial body. It was widely known that there was an undisputed connection between the General Manager of their employing hospital and the union: the General Manager had previously occupied a senior post within the executive of the nurse's union. The role of the industrial body in its

representation of the whistleblower nurses was discriminatory and not in keeping with its mandate to represent the industrial interests of nurses registered in the state. The industrial body failed to protect the interests of the nursing profession (New South Wales Nurses Association, 2009).

The nurses from this research study did not make contact with the industrial body as a group because they were not in contact with one another. For a substantial period, each nurse was unaware Narissa was portraying them as a group of whistleblower nurses. It was not until the parliamentary inquiries began and the nurses received invitations to give evidence that the idea of 'a group of whistleblower nurses' was conceived by the media. The nurses never represented themselves as a collective group. Each nurse independently made her own decision about whether to contact the industrial body. Each described her decision as influenced either by her perception of cronyism between the industrial body and the General Manager of the relevant employing hospital, or from past experience of the disinclination of the industrial body to become involved in situations that were unlikely to be easily or successfully resolved.

Scope of Practice and Whistleblower Nurses

Have you ever worked outside what you know to be your lawful scope of practice?

The literature confirms there is considerable variation in practice between jurisdictions, health care settings and the expectation of nurses in their daily

clinical practice (Gibson & Heartfield, 2003; Heartfield & Gibson, 2005; Stringer, 2006). It seems the demarcation lines regarding scope of practice are blurred by practice guidelines that sometimes are in conflict with the best interest of the patient (Milson-Hawke & Higgins, 2003, 2004). Parley (2002b) acknowledges caring as fundamental and conflicting to the ethical basis of nursing. Bowden (2000) while acknowledging the pervasiveness of the culture of care within the profession, acknowledged the concept of care as a reason why nurses may choose to act outside of their scope of practice.

The concept of maternalism is relevant to Simone who described the patient as 'her child'. Maternalistic behaviours according to Christensen and Hewitt-Taylor (2006) are commonly exhibited by nurses, who, under the premise of caring enact inherently maternalistic behaviours within their nursing work.

Monique:

Oh always! Always! That is one of the reasons these incidents occurred at the hospitals I worked at. I took the opportunity to do the advanced resuscitation course ... literally managing the patient. Many years ago there was a shortage of doctors. The Nursing Director of Critical Care developed the expanded role [for registered nurses]. We had guidelines...

Meadhbh:

Absolutely not! That was one of the issues I addressed when I went to my hospital. It was usual practice for scrub nurses to act as first assistant [to the surgeon]. They were being instructed by the Director of Nursing to do this. Except nobody read and realised that we are responsible for our own actions and by saying the General Manager [or

Director of Nursing] said you are to do it, does not safeguard you. If you act outside of your realm of knowledge and you become first assistant, then you are going to be judged as a first assistant.

Violet:

Many times, many times. One particular incident comes to mind ... I had a patient who went into complete heart block and needed a pacemaker and we had no one on night shift to put in a temporary pacemaker. The doctor from Emergency decided he was going to treat the ischaemia by ... and I am not kidding ... giving Anginine and putting up GTN ... I point blank refused. Now this patient was going to die, very, very soon. I was crying my eyes out while he was abusing me. I went into the treatment room and I drew up Isuprel and I set up an Isuprel infusion. He [the Emergency doctor] saw me do it. I did it all on paper. I kept that man alive until morning until the doctor came on duty and put in the temporary pacemaker.

Yanaha:

Yes I have, yes. I don't think willingly is the correct word, knowingly yes. When I was put in situations in that operating theatre, time and time again, particularly when I was in the role of the anaesthetic nurse, because the anaesthetists wouldn't be in the room when the operation was ended, the anaesthetic had to be reversed and the patient had to be transferred from the operating table to their bed and the anaesthetist was nowhere to be found ... On the surgical side of things I have worked outside of my scope of practice because I had to give advice to surgeons who for instance didn't know how to operate bowel stapling devices and things like that. Or when asked during an emergency bowel resection 'how does this one work?' I consider that to be outside of my scope of practice but in the interests of patient

welfare, you need to step in. But I am doing the best thing for the safety of the patient.

Simone:

The Nurses and Midwives Board contacted me about the incident where in the middle of the night; I couldn't get the doctor to attend the patient. It was the incident with the Laerdal bag ... it was the incident of trying to calm the patient down. My lawyer responded to the allegations. They [the Nurses and Midwives Board] said they were having a hearing. I wasn't invited to the hearing, but I was allowed to be present. After the hearing they sent me a letter saying 'whilst we are taking into consideration your distress at not being able to get a doctor, we hereby advise you, that you acted outside of your scope of practice to administer a Laerdal bag to the patient'. There was nothing put on my record, or limit on my practice or anything. It was basically a literal slap on wrist. Did I act outside of my scope of practice? The Nurses and Midwives Board said yes I did. I have no comeback to that.

Kathrine:

When I worked as a midwife in a rural area in New South Wales in the '80s, I was as usual the only midwife on duty. I called a General Practitioner to attend to one of his patients who was experiencing a delay in birthing her baby. On arrival, it was clear to me, the patient and her husband that the doctor was profoundly affected by alcohol. The woman needed to be delivered by forceps. The doctor was so intoxicated he couldn't position the blades and deliver the baby. I positioned the blades and talked him through it. The baby was delivered – not breathing - but delivered. I resuscitated the baby who would have died if I had not behaved as I did.

The nurses with the exception of Meadhbh all admitted they had acted outside what was a reasonable and lawful scope of practice for persons of their training and experience. Monique, Yanaha and Kathrine through the acquisition of experience as senior clinicians, based their scope of practice violations on the assumption the application of skills beyond the usual nursing framework would reduce an otherwise significant risk to their patients. Each nurse took the gamble as part of their duty to advocate in situations that could easily have resulted in the death of their patients. Simone was found by the Nurses and Midwives Board of New South Wales to have worked outside her scope of practice when she offered the Laerdal bag and advised her distressed patient:

“Here put this on, this will fix you up you know”. So he breathed in and I depressed about 100ml of air and after about a minute he had something to focus on so he calmed down and went to sleep. He called out once or twice and pretended ... no not pretended felt again that he couldn't breathe and I said to him “No you are okay, you have that [the Laerdal bag] now. You are fine,” and he settled back down again.

What other choices were available to her? She could not get medical help. There was only one doctor on duty. The patient relied on the Simone to help him – which she did, by the use of deception in the form of the placebo benefit of the mask. It seems incongruous the inquiry would focus on the nurse who was struggling, unsupported with a distressed patient, as opposed to the lack of medical support and intervention.

Having experienced being labelled, what now is your definition of a whistleblower?

The Code of Professional Conduct for Nurses In Australia decrees 'nurses have a responsibility to the individual, society, and the profession to provide safe and competent nursing care which is responsive to individual, group and community needs, and the profession' (Australian Nursing and Midwifery Council, 2008b, p. 1). It mandates each nurse accept a 'moral duty' to apply 'professional judgment' by means of the provision of ethical practice (p. 4).

In reality, as Light (2001, p. 1) points out, nurses are called upon to be accountable to the patient, while there is no acknowledgment of the fact that nurses have little power within the healthcare system. It would seem the demand for ethical practice places the nurse in a most precarious position; for at what point does advocacy become whistleblowing? When is the level of advocacy enough? Does the concept of advocacy have a ceiling of acceptability?

Healthcare today is cost-driven. Decreased spending leads to dilution of skill mix when less qualified workers are employed to do the job of more qualified staff because they are less expensive. Terms like multi-skilling and resource allocation are synonyms for doing more (not so well) with less. Emphasis on cost containment, as Light (2001) claims, places nurses in a situation where, if client safety is compromised, the nurse may be forced to advocate for the patient by becoming a whistleblower. However, as Sloan

(1997) notes, nurses also 'are fired for doing the right thing' (p. 14). Advocacy is identified in the literature as a crucial element in why nurses blow the whistle (D. Davis & Konishi, 2007); it is therefore important to understand why they risk so much in full knowledge that to speak out for their patients may bring 'retribution, repercussion, labelling ... ' (Kingston, Evans, Smith, & Berry, 2004, p. 37).

Monique:

I think to me, it is someone who is speaking out. They have had enough! They can't rely on management and need to do something about the problem. To me they are the true blue people because they have had enough and they want resolution. They make people more aware. I think from management's point of view, whistleblowers are troublemakers. I could have spoken out ... I was too scared ... of management. They were destroying me. I think [it was because of] where I was in my life ... I was divorced ... so I failed at my marriage. I felt I failed as a mother.

Meadhbh:

Like that nurse from Bundaberg [Registered nurse Toni Hoffman, who blew the whistle on a surgeon when no one would listen to her patient care concerns (Barraud, 2006)]. She is from our era. She, like us, had such a belief in what we are doing in relation to the care of our patients and that we are prepared as we did put everything on the line for it.

Violet:

It means someone telling the truth when they feel they had to because it has been hidden by everybody else.

Yanaha:

I think a whistleblower is somebody who is working in their professional environment who sees open corruption, that sort of thing and goes public with the information.

Simone:

I don't think I am a whistleblower, I think I am just a nurse doing her job. The thought of being a whistleblower terrifies me, but what terrifies me so much more is the thought of what I would be if I just walked away. What would that make me? That thought terrifies me far more than the fact that I lost money, lost relationships and I lost my identity when I exposed myself. That someone, who was so very private, had to put themselves so publicly out there and say so loudly what I thought ... but the thought of being that person terrifies me so much more than the thought of being the another person ... one who sat still...

Kathrine:

It never occurred to me that I would be labelled as a whistleblower. I acted in the capacity as the representative of the Chief Executive Officer of the Area Health Service. I advised of a sentinel event as reported to me. That was my job and I did it.

The literature supports the nurses' belief that speaking out about their patient care concerns is an inherent, intrinsic part of being an ethical, professional nurse who is a patient advocate (Ahern & McDonald, 2002; Macciocchi et al., 2009; Vaartio et al., 2006) as opposed to a nurse who is a trouble-maker, to be feared or not trusted. The term 'whistleblower' is a label none of the participants in this study acknowledges or accepts as

applicable to her. The nurses of this study do not regard themselves as whistleblowers; rather, they perceive their actions as those of patient advocates:

Violet:

We [advocates] have such a belief in what we are doing in relation to the care of our patients, that we are prepared, as we did, put everything on the line for it.

Yanaha:

I think people who are prepared to speak up and stand out have something different in their character. I am not saying better than or the people who don't do it are lesser than, I just think um ... we have a different facet in our character that allows us to do it.

Meadhbh:

[A person who tries] to get the relevant people to notice the problems and actually do something about them.

Simone:

I think I am just a nurse doing her job. I don't know what I would be if I hadn't [spoken out].

Monique:

I think to me it is someone who is speaking out. They have had enough! They can't rely on management and need to do something about the problem.

Kathrine:

Escalation of concern is a fundamental part of good, safe nursing practice. Nursing is all about patient care and patient safety – even

when the people you report to don't want to hear what you have to say.

Each of the nurses advocated for their patients, as is professionally expected. However, the act of advocacy once public becomes something more sinister, particularly if it is represented as an act of disloyalty towards the employer.

In the course of these interviews, you may have relived your whistleblowing experience. Given those reflections, if you had the opportunity to go back to a time prior to the events that happened to you, would you make the same choices?

Advocacy (Vaartio et al., 2006), professional ethics (Ahern & McDonald, 2002) and the Australian imperative to 'do-the-right-thing' (McAlpine et al., 1997) underpin the values of the nurses who spoke out publicly. The experience left the participants wiser in terms of being aware of the impact exposure by the media can have upon reputations of perhaps naïve but well meaning nurses.

Meadhbh:

I went through all of the channels, including the union and nobody would listen. So I don't truly see myself as a whistleblower.

Simone:

[Whistleblower] I have hated the term. In fact if I see it in regards to anything I think I don't want to be in the club – thanks! I don't want to be in the club ... All I ever wanted to do was to do my job. I never set out to do anything except do my job...

Violet:

I don't see myself as it [a whistleblower] ... I just see myself as [long pause] as someone who told the truth, who was morally and ethically correct and told the truth...

Yanaha:

I have never been comfortable with that ... label ... the definition of a whistleblower, I think, is somebody working in their professional environment sees open corruption, that sort of thing and goes public with the information. Which isn't how I saw our situation ... I still don't understand it. 'Cause all I did in my view was what I was supposed to do. I alerted my seniors to concerns that I had about the clinical competence of another healthcare professional and I ended up losing my job because of it.

Monique:

I have done nothing wrong. I have done the right thing and I am the one that had to leave.

Kathrine:

How could I have been labelled a whistleblower when escalation of a situation likely to invoke the interest of the media was part of my job description?

There was a clear shift in the way the participants responded to the 'would you do it again' question first asked in the first round of questions in Chapter 4. The participants, with the exception of Meadhbh, have indicated they would still speak out publicly about patient care concerns if their issues were

not addressed adequately or appropriately within their employing organisations; however, they would do so selectively and with caution.

Monique:

I would make the same choices. But I wouldn't trust the system. I kicked myself afterwards. I think I should have gone home and rung the police that night and told them that I was confident that the patient had died in suspicious circumstances ... but made it anonymously. I did do it again. That night you were on [Kathrine on duty as an After Hours Manager]. You protected another patient ... I remember you saying to the ICU nurse that you would be making sure that her death was not expedited by drug orders from the ICU doctor. She was dying, but not fast enough for him! But she did die of natural causes. That is what nursing is to me. I can still see the husband of that lady sitting by her bedside waiting for her to die. [In the future] I would do it different. But I would never NOT say anything.

Meadhbh:

I don't have the same faith in people that I had. And maybe my faith was naïve. I never believed that there were people out there who would set out to destroy somebody. I mean in politics yeah, that is what they do. I am more selective about what I would say and what I would do around people. I choose my friends very carefully now, which can be very isolating. But yeah I believe I am much more cautious and wary ... if I sense there is surgeon ... and I am aware that there are problems ... I ain't goin' there again. I am very clear I ain't goin' there again, because emotionally and physically I just couldn't deal with it. And yes it is the ostrich with its head in the sand, but it is time for somebody else to do it. I will never put myself on the line again.

Violet:

Yeah. I would do it again ... because you have to. Not that anyone is telling you that you have to. You have to do the right thing. It is like us when we look at murderers and we ask how could you live with yourself after you have murdered someone? You are hiding something ... not doing the right thing.

Yanaha:

I would. Absolutely I would ... I know that. I would be the first person to speak out. I won't stand by and watch a patient being harmed. I would, because I have to ... it is some intrinsic law in me maybe and I guess that is why I don't want to ever again come across it.

Simone:

I love my job and I know that I am very well respected in my job. I still love it, I still have a passion for it, I still believe it is for me but I guess it is like a marriage ... I love it, but I am not *in* love with it anymore and when you are not in love anymore you just go through the motions ... But the thing that burdens me the most ... is that if only I could go back a bit and change some of the things and the way that we did them, we would have been more successful. Because ultimately it is a game ... and you know you have to be on top of the game.

Kathrine:

Yes. Speaking out was never optional for me. In the future, I will still speak out however I will pick my battles and be better prepared to deal with unsupportive managers and systems that don't protect truth tellers. I regret unwittingly being drawn into Narissa's often hysterical and grossly exaggerated agenda against public hospitals in New South Wales. By virtue of both of us being employed by the same Area

Health Service it was easy for the media to group myself with her and the other participants as a rogue vigilante group of whistleblower nurses. Nothing could have been further from the truth.

It seems nurses are compelled to speak out for their patients. However, a lesson learned by the participants of this study is to be more selective about the battles in which to engage because the ramifications for the nurse are significant. This study confirms there does however come a point at which a nurse must measure the cost of advocacy against the physical and or emotional costs to the person who speaks out. Meadhbh, as her declaration 'I ain't goin' there again', indicates, has reached that point. The nurses of this study, while committed to patient advocacy and patient safety, realise that nurses have limits – and Meadhbh has reached hers. As an advocate for her patients, she believes she protected her patients to the best of her ability, but the costs to her both personally and professionally, as for the other participants, were life-altering; and the prospect of a repeat of that experience is, in her view, untenable.

While the rest of the participants say they would again speak out publicly if the situation warranted such drastic action, it would be in extreme circumstances only, as they know the consequences if they again advocate publicly for their patients.

Conclusion

Whistleblower nurses experience a myriad of consequences in retaliation for their act of speaking out. This research has found the main corollary of truth telling is psychological distress and pervasive fear, manifesting itself in physical symptoms such as persistent tremor, propensity to infection, anorexia, chemical dependence, paranoia and addictions. The psychological effects of being branded a whistleblower can be life-long, with erosion of self-confidence and self-esteem as long-term consequences. The fear of being identified as a whistleblower is cited as the catalyst for the breakdown of intimate relationships, derailed careers, financial ruin and personal despair.

The nurses in this study who were financial members of the industrial body chose not to involve the union, either because of a perceived lack of faith in the level of support they would be provided or because there was a belief an inappropriate relationship existed between the executive of the industrial body and the incumbent Labor government. With the exception of Meadhbh, the participants averred should a similar event occur again, they would again speak out to protect their patients. Patient advocacy has played a significant part in the nurses in this study being labelled whistleblower nurses. This point is exemplified by Simone, who willingly and knowingly acted outside what was her lawful scope of practice to protect her patient.

The telling of their truths by Narissa not only propelled each of the nurses into the media spotlight, but resulted in extreme personal and professional expense for all the participants of this study. Chapter 6 will explore the personal, professional and social futures for each of the women who were labelled a whistleblower nurse.

Chapter 6:

The Future

Some choices we live not only once, but a thousand times over, remembering them for the rest of our lives.
-Richard Bach

Whistleblowing is seen as an extreme act that is deserving of extreme consequences; it is described by McMillian (1989) as 'principled organisational dissent' (p. 93), and has been compared to heresy, mutiny and political discord under totalitarian regimes (Martin, Baker, Manwell, & Pugh, 1986). After speaking out, these participants confirmed that it was shattering to discover that organisations support deviance while victimising the person who raised an issue of concern (Lennane, 1993, p. 667):

Meadhbh:

The absolute lack of regard [by the organisation] for their patients and the pain they were willing to do to good nurses who wanted to do the right thing.

Simone:

It all comes from what is tolerated and what is not tolerated in the management system ... write everything down! Copy, photocopy and never, ever, ever, ever meet anyone ever in a position higher than your own without an independent witness. Someone who is ungettable by the hospital management and who hasn't got any ties what so ever

with the hospital who would be seen by anyone from the outside as being independent, even if it has to be a priest!

Yanaha:

It is a culture that [pause] you close ranks and you close your eyes to the bad stuff and people always seem to want to make excuses for when things go wrong.

Violet:

Stay anonymous, because there is no protection so you do it and you stay anonymous and you can't trust anyone in the health system and you can't trust they will do anything about it.

Monique:

As you work your way up the ladder these days, you have got to knock ten people down to get where you want to be...

Kathrine:

Governance in healthcare is an illusion, for it is only the revealed, discovered or uncovered that is reported upon. Trust no one but yourself.

In 1993, Lennane conducted a survey involving thirty-five participants from various occupations to examine the response of organisations to whistleblowing, and its effect upon individual whistleblowers. What she discovered she described as 'shooting the messenger'. Lennane (1993) found organisations 'use whatever resources necessary, for as long as it takes, to wear the lone whistleblower down' (p. 669). She asserts the aim of this response is to isolate and create a perception that the whistleblower is

incompetent, disloyal, troublesome, mentally unbalanced or ill; and contends that the purpose of this type of treatment of whistleblowers is to force them to leave their job, to alienate them from their colleagues and to avoid addressing the issue of which the whistleblower has complained. The principle finding of Lennane's study (1993, p. 669) is that for the most part, whistleblowers are left after the event in poor health, in poverty, and with their career in ruins. Today, little has changed (A. Yildirim & Yildirim, 2007).

After government investigations into complaints handling by public hospitals in New South Wales were completed and the media lost interest in the women who spoke out about patient care and advocacy concerns, the nurses were left to face futures in which they were known as whistleblowers. The narrative of each of nurse demonstrates an acknowledgment of their whistleblowing experience and indicates how she intends to move on to the next stage of her professional, personal and social life.

The long-term consequences for whistleblowers are well documented (Ahern & McDonald, 2002; Lennane, 2000; Simons, 2006). There is however, little indication in the literature of the long-term consequences of whistleblowing to the future of the nurse within his/her profession. To determine these, it was important to capture any longitudinal effects of being labelled whistleblowers for each of the participants.

Do you think there have been any long-term consequences for you professionally, and what does that mean for you as a nurse in the future?

Monique:

Oh ... I just take every day as it comes. I am surviving [working as an Agency nurse] and at the moment, I am happy...

Meadhbh:

I want out of nursing [working as a clinician] ... I am the educator for the operating theatre at a private hospital in Sydney. I am looking at doing the Cert IV [Certificate 4] with a view to going to do some training in the universities. I am working with students now and I am running the peri-operative course.

Yanaha:

Working in a private hospital I am selective about the surgeons that I will work with. There are still things going on all the time. My strategy [chuckle] is to not be where those things are. I intend to continue working until I am about 65 – not full time. I intend to work full time until I am about 60, and then probably part time for another five years and then ... walk away.

Violet:

I will never nurse again and the reason being is because of the way that they [management] turned [on me] I don't believe that I would ever be able to work without them looking to be able to find a problem.

Simone:

I feel disassociated from my colleagues ... I feel very much that I am no longer part of the ranks. [Now working as an enrolled nurse in operating theatres in a major tertiary referral hospital]. I would have

to say first, ostracisation ... I felt totally ostracised [as a consequence of speaking out].

Kathrine:

I have been informed that NSW Health has imposed a lifetime veto upon me ever again being appointed to a senior nursing position within the New South Wales public health system. I honestly didn't think I would ever recover from the loss of my career. The void in my life left me, for years, empty and sad. It took a simple turn of events to help me to see that a successful future is still possible, albeit down a far different path from the one I ever imagined it would take. I have written my first book of fiction, which has been assessed as having high commercial probability. If my book sells and writing becomes a viable option, I will walk away from nursing forever to become a full time author. In this case, indeed the pen will prove mightier than the sword.

Long-term Consequences for Whistleblowers

Rowell (2005) suggests workplace targets of bullying are 'predominately 40-ish, educated and veteran employees; specifically people who have experience with the employer before the bullying interferes with their careers' (p. 377). The literature confirms whistleblowing is rarely a success and is often personally and professionally risky for those who choose to speak out publicly (McDonald & Ahern, 1999, 2000). D. Jackson (2008a) note 'the literature on the topic and its consequences is relatively scant' (p. 1261), and suggests whistleblowing is possibly a career-ending event that may attract hostile, retaliatory consequences including organisational

retribution (Martin & Rifkin, 2004). McKenna, Smith and Poole (2003) and D. Jackson, Clare and Mannix (2002) confirm nurses who are exposed to bullying are highly likely to leave their current position, or nursing as a profession.

Table 6: The participants and their current work situation

Name	Role prior to labelling a whistleblower	Role today
Monique	Senior intensive care nurse	Registered nurse works for a nursing agency
Meadhbh	Clinical nurse specialist – operating theatres	Clinical nurse educator – perioperative unit in a private hospital
Yanaha	Clinical nurse specialist – operating theatres	Scrub registered nurse for select surgeons
Violet	Clinical nurse specialist – intensive care	Unemployed; will never nurse again
Simone	Enrolled nurse on a generalist ward	Enrolled nurse in operating theatres
Kathrine	Senior Nurse Manager – Level 3	Clinical midwife permanent night duty

Table 6 indicates all the nurses involved in this study are now working in different roles to those undertaken at the time of the whistleblowing event. Monique was forced out of her job as a senior intensive care nurse after she reported the suspicious death of a patient. Coyne, Chong, Seigne and Randall (2003) state competitive or intensive work environments have been associated with higher levels of victimisation. When drug abuse allegations were made against her, she confronted her local manager. She experienced

similar outcomes to those identified by Cortina and Magley's (2003) study of worker mistreatment, when she was victimised, her work environment was made intolerable, and she was forced to leave and find employment elsewhere.

Meadhbh and Yanaha were both stripped of their Clinical Nurse Specialist status and dismissed from their positions. They were not offered any explanation of the allegations brought against them, nor were they offered any evidence as to the complaints raised against them. They were escorted from the premises and told not to come back to work. The dismissal of these two nurses is an example of applied intimidation (Musselman, MacRae, Reznick, & Lingard, 2005; Nadzam, 2009; Tibbo, De Gara, Blake, Steinberg, & Stonehocker, 2002). Bolino and Turnley (2003) refer to the practice of intimidation and humiliation as a management strategy 'in which individuals let others know that they can make things difficult for them if they are pushed too far by dealing aggressively with individuals who get in their way, or by using forceful behaviour to get colleagues to behave appropriately' (p. 238). Leymann's (1990) study explains the expulsion of these two nurses as a deliberate act of being set upon by an organisation, using humiliation, degradation and the practice of exclusion as a profound example of workplace violence.

Violet states she will never work as a nurse again. The stress of the events occurring in her career as an intensive care nurse, coupled with her

willingness to speak out about adverse patient outcomes has, as described by Leymann (1996), impacted negatively on her health and wellbeing with lasting physical damage. The high levels of stress (Einarsen, Hoel, Zapf, & Cooper, 2003) she experienced have precipitated psychological distress in the form of low self esteem, depression and suicidal ideation. As a direct result of the fear she associates with her experiences as a nurse, she cannot resume her career. Violet's experience is reflected in the findings of a study of Turkish nurses, where ten percent of the participants said they contemplated suicide because of workplace bullying (A. Yildirim & Yildirim, 2007).

Simone described feeling marginalised and disassociated from her colleagues. Lennane (1993) notes when an employee appears to go beyond what is considered acceptable to the organisation, colleagues will often side with the employer as part of the authority system. Specifically, 'obedience to authority and group conformity is central' (1993, p. 669); and most people will act as expected by their employer, including adopting deliberate marginalisation tactics and disregarding personal morality by ensuring the organisation, not the actual bullier, is deemed responsible for negative behaviours directed towards employer-defined targets. Aquina and Thau (2009) shed some light on Simone's experience: they find 'workplace victimisation occurs when an employee's well-being is harmed by an act of aggression perpetrated by one or more members of the organisation' (p.

718). Also, an employee's well being is damaged when fundamental psychological and physiological needs are unmet or thwarted. Stevens and Fiske (1995) confirmed employee harm by victimisation to be destabilising to the employee's place in the workplace social group. This was the case for Simone, as she perceived she was robbed of a sense of belonging, with no control of her environment or ability to trust others.

Whistleblowers, according to Sawyer, Johnson and Holub (2006), are regarded by colleagues and managers with suspicion, and are marginalised and treated as outsiders. The Director of Nursing who employed Kathrine as a clinical midwife verbally confirmed Kathrine's career veto from future nursing promotions in the state of New South Wales. This ban is pervasive and long-term (Rothschild & Miethe, 1999, p. 110) and is due to her being marked as an insidious 'master' whistleblower – that is, she is viewed by the profession as a high-profile whistleblower who is considered by NSW Health to be very likely to speak out again.

Rothschild and Miethe (1999) confirm in their study that ninety percent of whistleblowers would, despite reprisals and punishments still report misconduct if the circumstances arose again, confirming whistleblowers are highly likely to be repeat offenders. Rothschild and Miethe's (1999) study also found that sixty-four percent of whistleblowers were blacklisted in their chosen field. Kathrine maintains she will always speak out and advocate to whatever level necessary for patients under her care; as long as she remains

in NSW she will remain blacklisted. It seems if the organisation is sufficiently determined, the single individual will be made an example of then rendered dispensable. In Kathrine's case, the point of Sawyer, Johnson and Holub (2006), who find removal from a whistleblower blacklist will only occur if there is a high degree of confidence that the person will not speak out again, is supported. Through deliberate marginalisation and exclusion of opportunity for career advancement she will remain at clinician level as long as she remains a nurse in NSW.

The nurses today all have different roles from those held when they were labelled whistleblowers. This has forced them to impose controls on their professional lives.

Monique:

I work for a nursing agency ... I just takes every day as it comes.

It seems her supreme distrust of management has left her with little option other than to work for a nursing agency where each shift is self terminating and where she has no responsibility to the clinical area she has been appointed to beyond the hours of work for which she is paid.

Violet:

I will never nurse again. I lost my job at the hospital and I am no longer a nurse.

Yanaha:

I used to be a multi-skilled perioperative nurse. I have narrowed my focus to just orthopaedic surgery because it is safe! I don't work with anaesthetists. I don't work with any other surgeons!

Meadhbh:

I am working with students now; I am running the perioperative course.

Yanaha and Meadhbh have both deliberately controlled the risk within their work environments by deciding to work exclusively with surgeons of choice or by making the decision to leave the clinical environment to become a perioperative educator.

Simone:

As an endorsed enrolled nurse working in theatre I cannulate, I take blood, I give drugs, I assist in massive procedures, I run alone level 1's you know wrapped infusers and cell savers I give blood, FFP, platelets ... I do it all, not the anaesthetist who checks the drugs. I intubate. I put LMAs [Laryngeal Masks] in...

Simone has opted to work in a tertiary hospital where she will never again be in a situation where she does not have a doctor to attend a patient. She willingly continues to work in a greatly advanced capacity for an endorsed enrolled nurse.

Kathrine has three options available to her: she can accept that if she continues to live in the state of New South Wales she will work in a clinical capacity and forego career advancement; she can seek to make another

career; or she can make the decision to move interstate and attempt to resume her management career path.

Kathrine:

Once this PhD is completed, I intend to move into the academic sector and share the knowledge I have acquired on this most inspirational journey.

Can you quantify the consequences you believe you may have experienced as a result of speaking out? For example financial, family, personal, social and personal implications?

Sawyer, Johnson and Holub (2006) confirm the typical whistleblower does not anticipate retaliation from the employing organisation. They offer a twofold explanation for this: first, as whistleblowing is usually a once-in-a-lifetime event, the outcomes of speaking out are not anticipated; and second, as Rothschild and Miethe (1999) point out, whistleblowing is never trifling and usually is associated with observed repeated violations of proper governance.

Hegney, Tuckett, Parker and Eley (2010) state 'nurses are at high risk of incurring workplace violence during their working life' (p. 188). The New South Wales Health Department has, in recognition of this fact, promoted a Zero Tolerance Policy along with workplace training, which has largely been unsuccessful (Farrell & Cubit, 2005; Maguire & Ryan, 2007; Paterson, Leadbetter, & Miller, 2005; Warne & Walters, 2006). According to Deans (2004) nurses work in the most violent industry in Australia – even worse

than that of prisons. D. Jackson, Clare and Mannix (2002) assert a link between bullying of Australian nurses and the current recruitment and retention crisis in the nursing workforce.

Lennane (1993) in her study of the effects of whistleblowing on thirty participants, found that seven lost long-term relationships and sixty of their seventy-seven children were adversely affected by the loss of long term relationships or through witness of the sadness experienced by the parent/carer who was labelled as a whistleblower nurse. Suicide was considered by seventeen of the subjects; while others experienced a three-quarter reduction in their mean incomes. She concludes: 'although whistleblowing is important in protecting society, the effect of that action when met with defined, typical organisational reactions results in severe and long lasting health, financial and personal problems for whistleblowers and their families' (p. 668). This was certainly the experience of the participants in this current research.

Social relationships suffer when a whistleblower becomes increasingly focused on the issues occurring in the workplace; this can cause them to feel that they have exhausted their personal and social support networks (Einarsen & Mikkelsen, 2003).

Monique:

Oh yeah, when I had to take time off work ... financial ... yeah – very much. I don't think any amount of money would undo what has been

done to me. Initially for my family at first it was a little bit of embarrassment ... The allegations ... the drug allegations and all that sort of thing ... where they actually mentioned my name ... I think they were proud of me ... I think they are still proud of me ... My mom ... not so much ... you know saying 'you were stupid,' but in a way even though she wouldn't say anything, I think she is proud of me. Whenever I go to work, she says 'now behave yourself' [laughing]. She still to this day says 'behave yourself'!

Meadhbh:

Look, no there were not financial [losses], but financial is of no value to me, money has no value. It was the loss of myself and the absolute destruction of my marriage and the subsequent consequences for my children and none of us have recovered from that really. My son had only been married about three months when my husband left. He moved in here with his wife. They were really supportive to me and helped me get through it. But for the first year of their marriage, they were dealing with the consequences of the breakup of my marriage of thirty odd years ... My son of twenty-nine won't even acknowledge his father exists. My daughter came back from overseas and I had to deal with my kids crying on Father's day. I do blame the hospital that employed me, because I know I became someone different to who I was. I mean obviously, it [the hospital] on its own didn't cause it [the marriage break-up], but it certainly pushed the boat out. My husband ... my ex ... would tell you it was my obsession with that hospital and my lack of interest in him, my home, myself, all of those things that arose from this, because he saw no end to it.

Violet:

Financially ... big ... I lost my job, I lost my career, my future and my superannuation... so my security and independence. I lived off my savings for a year and then I had to go on a pension for the first time in my life and I never thought I would. I don't speak to my family, so I can't speak about that ... except for my son. It is awful when your son has to look after you at such a young age and see you crying ... to wake up one day on the lounge room floor crying and your son has curled up asleep on the floor next to you ... Our whole lifestyle has changed. I am not the same person ... You lose complete trust. I don't trust anyone. I don't believe in anyone ... I used to believe ... God will look after those who deserve it, but it doesn't happen. My whole belief system has changed actually. My psych [psychiatrist] said that was the day that I stopped believing in people. And I believe that to be true.

Yanaha:

Financially ... well I was compensated. I was lucky. I think Meadhbh and I were both extremely lucky because our case came to a head right at the height of everything and the Department of Health was very keen to put it to bed. They were very keen to settle ... I try not to talk about it too much, because I don't want to bore people and I don't want it to be the sum total of who I am, and after a while, no matter what the disaster is that has happened, people do get sick of hearing about it. I think they do and I try to remind myself 'now don't talk about it because people are sick of hearing about it! Put it to bed!'

Simone:

Financial ... it is really difficult to quantify because it was very untimely; my husband became retrenched at the same time so it is very hard to put a money value on it. If you sat down and wrote it all

out, I got paid out eighty-nine thousand dollars plus legal expenses, so it was about one hundred and ten thousand dollars. Now I have this house and it is mortgaged to the maximum ... there is nothing left. The eighty thousand I got paid out ... I had had no wage for two years; I had borrowed from my father forty thousand dollars. The other forty thousand, I had some on credit cards, bills and things like that. So from a financial point of view ... we have estimated that it has probably cost us one hundred thousand dollars. It changed my identity really. My husband says I am not the same person and our marriage has suffered greatly – greatly. I don't know that it won't be over ... My daughter said to me one day, 'Why did you have to be a whistleblower nurse? Why did you have to do that? Why couldn't you just let one of those other people do that? Why did *my* Mom have to do that? Why couldn't you just be *my* Mom? [sobbing]

Kathrine:

Absolutely! In order to receive the monies owed to me, I was forced by the Area Health Service lawyers to sign a waiver that I would never bring a lawsuit against the service. I received poor legal advice and signed the waiver. My wage as a senior nurse manager was halved when I was forced to accept a clinical position. My mortgage of course was brokered on my original income. As a consequence, I have for years now had two jobs. I work full time night duty as a midwife and my second job is at a private hospital working one twelve hour night shift a week. So ... fifty-two hours a week, every week, to ensure the bank doesn't foreclose on my home. Of course the investment portfolio was an enormous loss, not only in terms of the change to our retirement plans, but in the accumulation of significantly more debt to get out of those contracts. My husband and I attempted once to calculate the financial losses, including the loss of the properties,

income and additional interest paid because of increased mortgages. We stopped calculating when we got to about three million dollars, which is somewhere near what we will be out of pocket by the time I retire – which, God willing, will be well into my seventies. As for my family, they have stood by me and are proud that I told the truth. However, they understand first-hand what it is to be a whistleblower and what it is to suffer because of it. It is sad when children comprehend that kind of suffering. As for socially ... when something like this happens, it doesn't take long to figure out who your friends are. The sound of retreating feet was deafening when I was splashed across the media...

The participants of this study were all treated harshly, they suffered significant career, financial and personal losses as a result of being labelled whistleblowers. As a result of radio and television interviews, Narissa advised each of the nurses she had been contacted by a Sydney law firm who specialised in medical negligence. She encouraged each of them (with the exception of Monique, who was unknown to her) to contact the law firm as a group and sue the Area Health Service for their losses. As a result the nurses were contacted by the law firm and evidence was collected with a view to litigate against the Area Health Service. Several months into the evidence collection stage, the law firm advised they were no longer in a position where they could represent the nurses as they had accepted another contract which presented a conflict of interest for the nurse's claim. After this the nurses were individually represented by other law firms. There was no collective 'fight back' attempt on the part of the nurses because they

were never a group in the first instance. Rather, each nurse sought individual representation independent of each other. This lack of group 'action' is testimony to the distressed, damaged state of each participant. A collective action could have been a powerful choice, but clear, appropriate decision-making was not possible for these nurses at that time.

The losses incurred by the participants of this study as a result of speaking out publicly were devastating.

Yanaha:

My career is back on track as far as what I want to do ... but I am frightened.

Violet:

Financially ... big ... I lost my job, I lost my career, my future and my superannuation ... so my security and independence.

Meadhbh:

It was the loss of myself and the absolute destruction of my marriage with the subsequent consequences for my children and none of us have recovered from that really.

Simone:

My husband says I am not the same person and our marriage has suffered greatly. But from his perspective, and I do understand this and appreciate this ... from his perspective he is thinkin', 'For God's sake there's hundreds of thousands of nurses in NSW why the stuff did I have to be dragged into this?' You know from his point of view it was okay initially for him to say I am proud of you and I love you and you

are a good person and this is why I married you. But after frigging five years you know and what we went through he is thinkin', 'Yeah I am proud of you and yeah you did a good job. But he said to me, 'God I wish it was someone else'.

Kathrine:

I hated the experience and I am sad that people are still afraid of me. But I am glad for the path the whistleblowing event has unfolded to me. My destiny is in the sharing of my acquired knowledge. My dream is to be a full time author.

Monique is pragmatic in that she believes there is no amount of money that can compensate her for the damage to her reputation and the loss of respect from her family. The time Simone spoke out coincided with her husband's retrenchment, compounding their financial difficulties and contributing to the erosion of their ability to communicate. Violet is no longer able to work as a nurse, the only form of employment she has ever known. Today, she survives on welfare and cannot see her financial situation improving. Yanaha and Meadhbh fared a little better in the financial stakes, but the loss of Meadhbh's marriage, which she has always attributed to speaking out publicly, is a great source of resentment for her. Kathrine's plans for a comfortable early retirement are lost.

While the financial losses are paramount for some of the nurses, the loss of relationships and friendships were equally as devastating.

Has your experience as a whistleblower nurse affected how you feel about telling the truth about adverse patient outcomes and patient safety?

All the nurses in this study appear to have impaired trust as a result of being labelled whistleblowers. Collegial trust, McCallin (2001) says, is a form of personal trust that is a measure of faith in colleagues to behave professionally and with integrity. The participants all shared their patient care concerns with Narissa who, in an attempt to highlight her own patient care concerns, betrayed the nurses by releasing their information to the media without their consent. Nursing in particular, argues D. Jackson (2008a), is dependent upon collegial trust, with faith in peers and acceptance of their word in terms of attended patient observations and patient care. D. Jackson (2008) considers violation of trust, although not cited specifically with regard to workplace bullying or mobbing, is by its very nature a breach of collegial trust (Dilek & Aytolan, 2008) that may be invisible to all but those experiencing it. Firth-Cozens (2004) states 'organisational trust is a fragile thing, broken more easily than it is mended and easily damaged by disconfirming acts' (p. 60). Breaches of trust, D. Jackson (2008a) acknowledged, evokes feelings of betrayal and anger that can be emotionally damaging not just to the whistleblower, but to workplace relationships and collegial trust. Workplace relationships in nursing are important; and fractured relationships can have a damaging effect upon the workplace (P. Jackson et al., 2010). It is clear that lack of trust in the profession of nursing is central to the decision each of the nurses in this

study has displayed: to adopt a position of safety to prevent herself from becoming a target in the future.

Monique:

Not yet! I am just trying to find a different way to do it [nursing]. [Agency nursing] Now it suits me 'cause I am not in a department. 'Cause if you are agency or casual [staff] and you are working in the same department, it is the same as working full time ... It suits me to work in a different ward every night, so that when the heat is on at the end of the shift ... I say what I need to say [and walk away] ... But I don't bring the shit home with me. I am trying to leave the shit where the shit belongs. I am not bringing it home, worrying and being angry and not being able to sleep. To stay in nursing and to be permanent somewhere, they would have won. I would have had to back down and just go to work and do my work and become one of the people with the blinkers on.

Meadhbh:

I have no problems with it. No problem. People think I am nothing but a trouble maker sometimes, because anything that happens I document it. Everything is incident reports. As I have said, regardless of the outcome – if it happened – I'm documenting it!

Violet:

I think I would still tell the truth. I couldn't live with myself if I didn't. I couldn't. You should be able to tell the truth [but] ... without your name and everything...

Yanaha:

It hasn't affected how I feel about telling the truth because the truth was ... the truth was all I had at the end of the day and I stuck very closely to the truth. I never wavered. I never said anything that wasn't true. The truth was all I had and I figured the only way I could survive and sleep at night and hold my head up was to tell the truth. Even though I am still fragile and can still easily have a melt down and feel like the world is coming to an end, I still tell the truth about incompetent practice ... I wouldn't try to hide from that ... I would put my hand up and would speak. I certainly wouldn't relish that opportunity and I don't want that opportunity but I believe in my heart that I would do it. But, I think that I would be a lot wiser this time.

Simone:

Yeah. I would have to say yeah if I were being truthful. I don't not get involved. I don't purposely dissociate myself ... But on the other hand if there was an incident where I had to put myself out there head to head with someone else within the operating theatre if I had a problem with their practice, I don't know how confident ... I mean I would be physically ill, sick ... almost demented. Because I don't ... I don't ... I have this really strong urge inside me, I don't want this whistleblower label. I don't want it to affect the way that people think about me [any more]. And it does! [emphasis] It really does.

Kathrine:

I am, because of my warrior spirit, a protector, so advocacy and truth telling for me are not optional – but I am much more selective when choosing my battles and mindful of my own welfare these days.

With the exception of Meadhbh, each of the nurses, if required again to speak out and tell their truth about patient care concerns, would do so – but more guardedly, less altruistically and more self-protectively. Monique works with a nursing agency, so at the end of each shift she can just walk away. Meadhbh protects herself by creation of detailed records of events. Yanaha works exclusively with surgeons of her choice. Simone does not want to do anything in the future that would cause her to again be labelled a whistleblower. Kathrine picks her battles carefully. Each of the nurses apart from Violet has, perhaps unwittingly, created a career vantage of safety, a position from which she can work as a nurse in relative personal and professional shelter from further recrimination and persecution. It is the lesson each of the participants has learned and adopted to enable them to continue to work as nurses. This finding is unequivocal for whistleblower nurses in the literature. The need to control personal risk in the workplace by the individual who has been identified as a whistleblower appears to be a psychological ramification of the extreme bullying situations described by Leymann (1990, 1996, 2006) as mobbing.

The nurses, with the exception of Meadhbh, have all agreed they would again speak out publicly. However, it seems being labelled a whistleblower impacts significantly upon the individual in terms of retaining the trust of others in the workplace. Monique works as an agency nurse, accepting self-terminating shifts that offer no guarantee of continuity of placement, but

also offer no expectation of involvement in ward activities or nursing politics. Working for a nursing agency makes Monique feel safe in that she deals with whatever comes on a shift by shift basis, speaks up when she has to and 'leaves the shit where the shit belongs – in the workplace'.

Meadhbh has learned to cope by overcompensation in terms of 'documenting everything' – which is her principle protectionist response. Her level of trust in the workplace has been severely affected. Violet, although unable to work again as a nurse, believes nurses should be able to tell the truth because the alternative is abhorrent to her. However, she advocates anonymous declarations should be acceptable, rendering the focus upon the event, not on the whistleblower nurse. Yanaha, like most of the other nurses, maintains she would speak up again, but is filled with dread at the mere thought of doing so. This experience has taught her many lessons – lessons that she will apply in the future to prevent this type of experience from ever being replicated during the rest of her career. Simone admits she would speak up again, but with reservation: she does not want to be labelled a whistleblower again. Her self-esteem and self-confidence are greatly diminished because of how she believes her peers perceive her now. Kathrine maintains she will always advocate for patients and the truth; however, the hard lesson is that as a patient advocate she must also advocate for her own wellbeing. Today she picks her battles; but if she does choose to engage, it is to win.

Do you think you have changed your practice? Have you created some way of keeping yourself safe now?

After speaking out publicly there is a period of professional uncertainty for the whistleblower, characterised by deep distress, increasing alienation and a sense of disillusionment as trust in organisations disintegrates (D. Jackson, 2008a, 2008b). Faunce, Bolsin and Chan (2004) list mental illness or distress among the outcomes commonly described as the result of whistleblowing. Einarsen and Mikkelsen (2003) confirm witness of bullying in a chronically hostile workplace evokes fear in other workers of becoming the next target, which in turn, leads to chronic anxiety. Attree (2007) records concern about detrimental personal consequences, coupled with little confidence in the systems for raising concerns, are disincentives to reporting of adverse events by nurses. Rosen, Kapustin and Morahan (2007) advise nurses who have been mobbed to document everything and create safe storage for their data away from the workplace. In a situation where there is little confidence in the organisation, nurses are left with three choices: to continue by reporting, documenting and participating in the process which they have lost faith in, to remain silent, or to go outside the organisation.

The deliberate removal of one's self from the clinical environment to reduce the probability of becoming a target again is a strategy used by whistleblowers (Einarsen & Mikkelsen, 2003; Quine, 2001; Simons, 2006). Job or role change as a result of bullying is also well documented (Daiski, 2004; Farrell, Bobrowski, & Bobrowski, 2006; Griffin, 2004; M. Lewis, 2006;

McKenna et al., 2003; Quine, 2001; Simons, 2006). Rosen, Kapustin and Morahan (2007) suggest it is prudent for nurses who have been mobbed to consider changing jobs to shelter themselves, so they are less likely to be targets. Leymann (1996) confirms mobbing undermines physical and psychological health, while (Quine, 2001; Rowe & Sherlock, 2005) identified decreased job satisfaction, altered or decreased work performance and attrition as consequences for the target.

McEwan (2008) states changing workforce patterns and the choice of alternative models of care have renewed interest in the role of the enrolled nurse in Australia. However, the literature confirms enrolled nurses experience frustration, feel undervalued, and consider there is a lack of respect and recognition for their contribution to nursing (Gibson & Heartfield, 2003; Gibson & Heartfield, 2005). There is increasing pressure to increase, expand or advance the role and the scope of practice for enrolled nurses (Australian Nursing Federation, 2005; Gibson & Heartfield, 2003; Kimberley, Myers, Davis, Keogh, & Twigg, 2004; Milson-Hawke & Higgins, 2003, 2004); however, in many instances enrolled nurses, because of role blurring and role confusion, are being asked to perform roles beyond their level of expertise, education and training, often without the supervision necessary to ensure safe practice (Gibson & Heartfield, 2003; 2005; Milson-Hawke & Higgins, 2003, 2004).

The nurses now express their viewpoints on how they plan to stay safe at work in the future.

Monique:

[Laughing] By choosing to be an agency nurse! That's it! I am doing what I love. But I like that because before, when I was working full time at a Sydney hospital, I was going to the same ward and the same shit! But now, I am not permanent. Nuh! The politics and the sweeping under the carpet – nuh! This way I can do what I love until I can't do it anymore, but still nurse the way I was taught to nurse.

Meadhbh:

The bottom line for me is that I want out of nursing! Yes, I want out of the [public] hospital system and spend my time thinking about what I am going to do. At the moment I am [working in a private hospital operating theatre], just starting Certificate IV and I am hoping with my experience as an educator in theatre that I will be able to get in somewhere to do some teaching. But there is no way I am continuing in the [public] hospital system.

Violet:

I am too afraid to be autonomous. I did try and go back at one point when I thought I was getting better ... I went to agency nursing ... I lasted five shifts and I was a mess. I couldn't concentrate, you know all the symptoms were there ... in the end I froze on my last shift. I came in on a night shift ... I can't even remember what was wrong with him [the patient] ... he arrested [cardiac arrest] towards the end of my shift and I had to give adrenaline. I rushed to the cart and got the adrenaline and I couldn't give it. I couldn't give it and I threw it at the nurse on the other side of the bed and said 'you give it' and I

stood back. At the end of that the supervisor said 'Do you want to go home?' I said yes and I left and didn't even ask for my pay. That was when I knew I would never be a nurse again ... I am ashamed.

Yanaha:

Now, I am guarded. I am very guarded with any situation that is anyway out of the normal ... I used to be a multi-skilled perioperative nurse. Now I have narrowed my focus to just orthopaedic surgery because it is safe! I don't work with anaesthetists. I don't work with any other surgeons ... this is a way of protecting myself ... I have to stay in my own little world.

Simone:

As an endorsed enrolled nurse working in theatre I cannulate, I take blood, I give drugs, I assist in massive procedures ... I give blood. I do it all, not the anaesthetist who checks the drugs, I intubate. I think that within my own mind, I will practice in a safe manner, being taught by professionals ... and that I do so to a safe level, that will not harm the patient and that I am educated ... I will not do any more than that ... and at times it will exceed what the hospital thinks I should be allowed to do, what you think I should be allowed to do, what the Nurses Registration Board thinks I am allowed to do. We all exceed our scope of practice; we are all capable of exceeding our scope of practice. And the only reason it is not universal is because we are not all capable, but most nurses are – particularly when they have been nursing for a long time.

Kathrine:

Safe? Absolutely! People are afraid of me. Experience has taught me to be paranoid and to be highly defensive in my practice now. Since becoming a clinician, I have been brutally targeted in the workplace,

and because I am unrepentant, they [middle and upper management] continue to target me. Interestingly, since the management of the hospital became aware of the subject matter of my research and its soon-to-be-completed status, I have been left blessedly alone. I need to keep me safe – I may not survive another experience like this. To keep myself safe, I ensure there is a paper trail of everything I do. Any conflict I diarise, any unusual events, I document voluminously in the patient record and again diarise. If we have difficult patients, I ensure my conversations are witnessed by a colleague, with countersigned documentation in the patient record. I leave nothing to chance now.

In order to continue to work in the profession of nursing, Kathrine, Monique, Meadhbh and Yanaha have put deliberate strategies in place, not just to protect themselves from another occasion whereby they may have to speak out publicly, but to protect themselves from the profession of nursing itself.

Yanaha today works in a private hospital exclusively with surgeons who she knows and trusts. This is the only way she feels she can continue to work as a nurse. Violet, despite her years of working as an Intensive Care nurse, is now afraid of the autonomy and responsibility required in a nurse. Kathrine acknowledges feelings of paranoia and a pervasive fear of the workplace. She is hypervigilant in her documentation of events either involving patients or other staff, to ensure no further criticisms or losses are incurred as a result of working as a nurse. She directly attributes this change in her nursing practice to the treatment she received as a whistleblower nurse

which has resulted in her being further traumatised by her horizontally violent workplace.

Simone has chosen to relocate to work in a tertiary referral hospital in operating theatres; where, by her own admission, she works outside of what is considered to be a lawful scope of practice for an enrolled nurse. She is confident she has been offered sufficient in-house education to enhance her skills to meet the requirements of advanced clinical practice.

Do you believe there is a need to protect nurses who advocate publicly for their patients?

Whistleblower law in Australia varies widely between the nine jurisdictions – federal, six states and two territories. In 1994, whistleblower laws were introduced in New South Wales. The NSW laws according to (Brown et al., 2007) are inadequate as there are not codes or guidelines as to how disclosures are to be made. There is no imperative to investigate or action disclosures, and no protection for people who make public disclosures.

All six nurse participants in this study attempted to raise their concerns via their management channels, with little or no success. Because of the inadequate whistleblower laws of this state, their disclosures were not in the first instance used to address adverse outcomes and occasions of significant patient harm, but became vehicles for professional retaliation, personal criticism and derailment of long-standing careers. The participants all believe

nurses need to be protected; however, the belief in the adequacy of that protection is quantified:

Monique:

Ah ... a need? How did that need come about? Years ago, you were praised [as a patient advocate]. Your manager or matron or whatever was proud and stood by you. So when did the need come about? When we took our oath, that was part of our oath, to be patient advocates ... So I don't know how there became a need to protect whistleblowers ... they weren't called that. Managers were firm ... and you are one of them. You [Kathrine] were always firm and professional and fair and there was none of this friendship factor and even if a friendship came out of it, it was separate from work. The fact is that if you are in a manager's role and if I need a kick up the arse, I was taught to accept that!

Meadhbh:

When we took our oath, part of our oath was to be patient advocates. They [management] are not supporting that ... if you do speak up well they are just going to shove it back down your gob and make you suffer! ... I think the first thing we need to stop is calling them whistleblowers ... I don't know that there is really anything that can protect you, if you have a system in place that says [if they make] trouble – get them out!

Violet:

I think it [the disclosure] has to be to an independent body because *they* are all connected to each other in the health system! [emphasis] Yeah ... well ... we know the system and the witch hunts ... otherwise they will end up like us! You know people don't do anything [to protect

nurses] and I think it will be the same for them. It is putting right from wrong so when they speak up they will be protected. We need to start a new generation of nurses that will speak up. But I think they should be anonymous. Because that is the start of it ... the environment collapsing on you [being named]. I really do believe they have to be completely anonymous.

Yanaha:

Yeah of course! But I don't know how you can do it because it is a cultural thing from within the profession and not just the nursing profession but the medical profession as well. It is a culture that [pause] you close ranks and you close your eyes to the bad stuff and people always seem to want to make excuses for when things go wrong. I also think there is a big tendency for personalities of health care professionals to be what they are judged on. Nurses shouldn't have to go to the media to highlight problems! They shouldn't have to blow the whistle, so they shouldn't have to be protected. I don't think there is any way that we can protect nurses who blow the whistle.

Simone:

This ... protected disclosure [Act] is as weak as piss! Well I think there is a need to protect anyone who blows the whistle ... and the main reason is ... if anything comes out of this [the current study], the biggest issue for me was that there is a [functional] Protected Disclosures Act ... The thing I would like to see is [address of] this Protected Disclosures [Act] ... I would like to see legislation where even anonymously nurses can make allegations...

Kathrine:

It is a paradox. Nurses are employed for their principles and their commitment to advocacy for their patients. But if in that expression of advocacy, the organisation is portrayed as lacking or wanting, the nurse becomes the target and is labelled a whistleblower – and not just for the moment – for life! Yes, nurses need to be protected. It is unreasonable that a nurse is rendered physically, psychologically and socially impaired in the course of executing their job. The problem of course is who do you trust enough to make a disclosure and expect it to remain protected information? It is all well and good to make a sensitive disclosure to your manager. However, it is what the manager does with the information and who that information is shared with that does the damage to the reporter.

It is an expectation that nurses will be truthful and advocate for their patients – this is an accepted, inherent part of the role. Yet when the nurse does speak out publicly (usually because his or her voice has not been heard up through the ranks of local management), the nurse is labelled for doing the very thing that is fundamental to the job – to protect the patient. Each of the people in this study believes the situation should never arise when a nurse should require protection from professional persecution, because advocacy is central to the role of a professional nurse. However, in the real and often harsh world of nursing, each has, through first-hand experience, come to realise that there are significant personal, professional, social and financial costs to the nurse who chooses to speak out publicly. The current whistleblower and protected disclosure laws do not protect whistleblowers.

Once the nurse is publicly named the focus of the issue is redirected from the issue of advocacy to the speaker: that is, the nurse. For two reasons the nurses of this study believe their colleagues should be able to advocate for their patients anonymously: to voice their concerns about patient safety, and to protect themselves.

On completion of each of the interviews did you experience any feelings, symptoms, flashbacks or concerns?

The participants of this study reflect the findings in the literature (Halse & Honey, 2005; Kidd & Finlayson, 2006; Minichiello et al., 1996), that they were negatively affected by the experience of being interviewed, and had to relive their experiences as whistleblowers.

Monique:

An open wound for any bastard to throw salt in ... the fear keeps coming back and it's always going to be there.

Violet:

I am scared ...

Yanaha:

I want to put the whole experience in a box and never think about it again.

Meadhbh:

The interview process was difficult.

Simone:

Oh it has been really hard [starts crying]. That last one ... you know I think it is good in a way, because it is really easy to push this down and to pretend everything is fine and go on. But you can't say ... and you can't do something like this and say it hasn't affected you.

Kathrine:

I relived my experience over and over and over again while the narratives of my colleagues hammered me like a hail of bricks!

The nurses all admitted to having suffered psychological trauma as a result of participating in these interviews. Nevertheless, they offered their stories willingly and with candour. They did so knowing the risk of resurrecting the anxieties associated with their experiences would probably exacerbate their levels of personal distress.

Monique:

Ah, well ... sometimes I cried. I have just had to accept and leave the shit where it belongs, it doesn't belong with me ... but it is a scar, and when you look at a scar, you remember how you got it and that it will never go away.

Meadhbh:

I am very willing to go through this process with you [being a participant in the interviews] but, it scares the bejesus out of me, because it [the fear] is coming back often. I mean I do feel choked up about it. I know the last time after you left I was wired. And that is not a criticism of you; it was talking about things that I had locked away. I don't think it is ever going to go away. It's always going to be there ...

suddenly Pandora's Box is open and I actually feel ... I physically feel myself droop. You know when you are in that semi-fetal position, it is like you want to protect your head, because you are going to get beaten. I felt beaten by them, physically beaten.

Violet:

When you have got depression, it takes every second of every minute of every day of every week to just move on to just get through the next second, the next minute and the next day.

Yanaha:

The whole experience is something that I just wanted to put to bed, it is difficult ... I just don't want to go there anymore.

Simone:

Oh it has been really hard [crying]. That last one [the second interview] ... you know I think it is good in a way [to verbalise], because it is really easy to push this down and to pretend everything is fine and go on. But you can't do something like this and say that it hasn't affected you.

Kathrine:

I totally underestimated what it means to be a participant observer in research. The interviews were extremely difficult because I knew the nurses of this study professionally, and some, I knew socially. For me it was the double whammy! I relived my experience ... not just once, but each time we met for the interviews and again and again when I revisited the transcripts. I felt like a masochist, wanting ... needing ... to hear and record the stories, while at the same time witnessing the pain and the suffering ... I was terrified I would invoke some recollection or reaction from the past that would harm them, because

in truth, they would never have offered anyone else the raw accounts of the experiences that they offered to me. My acute anxiety disorder gained during my own whistleblower experience roared to life not only when we met for the interviews, but again and again when I went through the narratives during the writing of this thesis. I thought the second round of the interviews and the writing of chapter five would kill me.

Kathrine experienced insider/outsider conflict (Minichiello et al., 1996) where, by virtue of thirty plus years experience of the public health system in New South Wales, she understood what it was to be a nurse while understanding what it was to be labelled a whistleblower. She could appreciate and understand the experiences of participants of the study; however, the intellectual curiosity required to collect the narratives combined with repeated exposure to the data during the writing of the thesis had a profound and negative effect invoking her extreme anxiety disorder: 'I was terrified'. This reaction, although not well expressed in the literature, has been described (Lalor et al., 2006; R. Lee & Renzetti, 1990) as a risk that researchers take when they participate in sensitive research.

Monique suffered physically when she had a heart attack that required bypass surgery. While none of the other nurses suffered such physical damage, all were significantly wounded emotionally and psychologically. The memory of these events, it seems, has fuelled lifelong fears and anxieties. While some degree of catharsis may be achieved in the retelling of traumatic

stories, fear in the remembering is a commonly experienced emotion. The fear associated with these memories appears to be central to the adoption of the self protection mechanisms each of the nurses has put in place in order to stay safe in the workplace. It was clear to all the participants that this strategy was the only way any of them would be able to continue to work in the brutal world that is nursing.

Conclusion

Whistleblowing, regardless of the intent, is an act of extreme dissent that is perceived to be deserving of equally extreme consequences. The literature and this research both determine that whistleblowing rarely achieves the desired outcome and is frequently disastrous to the person who speaks out, in ways as varied as financial security, professional standing and career longevity. The participants of this study all suffered significant professional and psychological sequelae which includes the imposition of an enduring professional ban on career advancement in the state of New South Wales (and potentially Australia wide), stripping of rank and professional status, depression, suicidal ideation and professional marginalisation and isolation. The experience of being seen as a whistleblower has caused each of the participants to appreciate the extreme personal risk undertaken by nurses who advocate for patients. They have come to realise that future occasions of advocacy must be more guarded, less altruistic and be inclusive of self-protection strategies. This realisation has caused each nurse to develop

individual self-protecting mechanisms by which they can continue as an advocate for their patients while keeping themselves professionally safe. They all, in recognition of their role as advocates for patients, reject the notion that speaking out about patient safety or poor patient outcomes constitutes blowing the whistle. They likewise reject the appropriateness of the label 'whistleblower' in favour of advocate, as advocacy is an expected part of the role of a professional nurse.

Whistleblower laws in the state of New South Wales offer little protection to nurses who advocate for their patients by speaking out publicly. The laws' inconsistencies and inadequacies permit professional retaliation, criticism and derailment of previously long-standing, professional careers. Participation in this research, while potentially cathartic, negatively affected each of the participants, who, through the telling of their stories experienced symptoms ranging from the resurrection of fears and anxieties which were considered to have been resolved, to depression, feelings of being physically beaten, and the onset of acute anxiety disorder.

The conduct of a sensitive inquiry is a significant responsibility for a researcher; this point is particularly true when the researcher is also a participant in the study. The effect of offering the stories as a participant is intensified by the ordeal of data collection and exposure to the narratives of the fellow participants. The negative effects of the collection of sensitive

data on the researcher are not well documented, and are deserving of further academic inquiry.

Chapter 7 will offer the reflections, conclusions and recommendations from this research that, it is hoped, will provide a platform for change and an improved future for nurses who advocate publicly for their patients.

Chapter 7:

Reflections, Conclusions and Recommendations for Change for the Future.

From participation comes discovery; a footprint in the future from the voices of our past. To leave a legacy is the most we can hope for.
-Kathrine Maree Grover 2011

It would seem the altruism of nursing, and perhaps professional naivety are the two main reasons why nurses need to be better informed about escalation of concern reporting. Firstly, there is an indisputable requirement for internal reporting of issues regarding patient care or patient safety. Secondly, nurses need to be warned and empowered with knowledge, strategies and understanding of the importance and appropriateness of the escalation process; for escalation outside the walls of the employing organisation can see a well intentioned nurse labelled as a whistleblower.

The literature (Ahern & McDonald, 2002; D. Jackson, 2008b; Martin, 1998; Martin et al., 1986) and this research confirm there is a great deal known about whistleblowing; yet, as the available research confirms, nurses do not heed the research, the warnings, or the literature about the consequences of speaking out publicly. This is a conundrum. Nurses are as vulnerable to the costs and consequences of whistleblowing as any other individuals. Nurses are not exempt from retaliative conduct that leads to personal, professional,

social and financial ruin. Internal reporting of patient safety concerns is fundamental to the role of a responsible nurse. A healthcare system that punishes those who are forced to speak out is a healthcare system that does not value truth. Nurses must take responsibility for their own protection.

The findings of this research are intended to empower all nurses, young and old, and enable them to better understand how people in a profession that is universally admired may be destroyed. These recommendations are intended to be an instrument for change in healthcare in New South Wales, beginning with the way in which the state reacts to the nurses it employs when they advocate for their patients – regardless of the level of escalation of concern.

Reflections

The demand for legitimate, self-governing professional status for nurses has prompted an increase in levels of professional autonomy with an expectation of legal, ethical, moral accountability and decision-making for individual practice that is reflective of patient advocacy (Vaartio et al., 2006). Nurses, like all health care professionals, have a responsibility to present their documented, measured, concerns via internal channels; with increasing internal escalation as is necessary for the issue to be addressed.

This study has argued that nurses continue to enact the moral principle of patient advocacy by speaking publicly of their concerns for patient safety

when their employing organisations have failed either to investigate or to acknowledge their claims. The nurse who takes this course is subjected to public criticism, humiliation or ridicule (Rosen et al., 2007) and becomes a professional pariah.

This research demonstrates there are five significant findings to be considered for nurses who speak out publicly.

- The media: Whistleblowing and the media.
- Labelling: Sticks and stones may break my bones.
- Career protection: Creation of a career vantage of safety.
- Mobbing: Retaliation against nurse whistleblowers.
- Australian legislation: A review.

Each of these findings will be considered individually. Strategies are offered for nurses now and in the future, to help protect them when they advocate for their patients.

The Media: Whistleblowing and the Media

This research confirms the six subjects of this study were misrepresented in the media by the application of bias in order to sensationalise the story. Bias through selection and omission was demonstrated by the media's deliberate, erroneous blurring and regrouping of the events raised by each nurse to portray a group of renegade whistleblowers.

The concerns of the whistleblower nurses became front-page news; promoting bias through placement by virtue of the fact that the front page of any newspaper is the most influential in terms of sales and the ability to sway public opinion. The media projected photos, video and television footage of the nurses who exposed adverse outcomes in some hospitals; these images were perhaps the most damaging to the reputations of the nurses. Their names were mentioned repeatedly. The print and media news were saturated with this information for months. These images deliberately promoted the sense of scandal by broadcast of the grief and upset of patients and relatives of patients who had experienced poor outcomes with photos and video footage of the nurses. Intense focus on the Area Health Service and the allegations of the nurses promoted a scenario of poor standards and poor outcomes and promoted bias through statistics and crowd count. The nurses were objects of a story narrated by the vested interest and purpose of the media and other players, the means by which opportunistic media promoted unrelenting, sensationalist headlines about the state of health care in a particular area in the state of New South Wales.

Findings from this Research

This research accepts the agenda setting theory as the rationale behind the media sensationalising nurses as whistleblowers. The headline 'nurse whistleblower' is shocking, challenging to public opinion and guaranteed to promote intense public interest. From this perspective, the recommendations

for the future are made. Nurses are inadequately informed about or prepared for public declarations of professional concerns. The Media Awareness Network (2005) demonstrates how the media with its applied biases affect public perception with its focus on spin rather than fact by targeting the goodness associated with nursing (*'names and titles'*) to generate public sympathy. The selective words used (*'source control'*), the size of the problem (*'statistics and crowd count'*) and the way in which the story is portrayed (*'selection and omission'*) and represented by photos of shell-shocked whistleblower nurses is media gold (*'photos, captions, camera angles'*). The words whistleblower nurse (*'headline'*) on page one (*'placement'*) is guaranteed to generate high levels of public interest and public concern. The agenda of the media is met and the nurse is left wondering how the situation went so wrong (pp. 3-4).

The media portrayal of the participants of this study as a collective of renegade whistleblower nurses was an illusion. The 'highly published allegations' (Independent Commission Against Corruption, 2005b, p. 6) of Narissa, the self-appointed spokesperson for the nurses, implied a relationship between herself and the other nurses that did not exist. In truth, the only two points of commonality were the nurses and Narissa were all employed within the same Area Health Service within the state of New South Wales and all of the nurses, individually and separately, publicly expressed concern for patient safety. As a result of the false impression

presented by the media, the participants of this study were thrust into the spotlight for many months. They were helplessly caught up in a maelstrom that was not of their making when they were sensationally labelled as whistleblower nurses; a label that was forced upon them and continues to be used.

Strategies for Nurses Now and in the Future

Nurses may be well versed in patient care and dedicated to sound patient outcomes, but most are in no way prepared to deal with the media. As advocacy is an expectation of professional nurses, the probability of encountering conflict and media attention is real. In acceptance of this fact, this research makes recommendations to universities and nurse educators and Area Health Services.

- 1.** The role of the media in public disclosures in healthcare must be embraced as a high education priority for neophyte nurses. The adage, *know thine enemy*, is relevant. It would seem reasonable that media tactics and their implications for nurses and healthcare, become part of introduction to nursing practice. The concept of public declaration by nurses must be broached at this early stage of professional development. Nurses must understand internal reporting of concerns is paramount. It is also important from the outset of their careers that nurses understand the politics, social ramifications and influence of the media.
- 2.** As nurses progress through years of study, they will benefit from inclusion of aspects of media awareness in their learning. Nurses need

to understand the internal escalation process, how to report, what to report, how to conduct oneself and how to use language effectively. The importance of professional, experienced consultation and representation in any and all interaction with the media, is an imperative. These strategies will all go a long way towards empowering nurses with enough resources to accurately present and depict their concerns in a professional and incontestable manner. Honesty in reporting is more achievable if the facts define the event; leaving journalists little scope for creative assumptions.

- 3.** Universities must be more transparent and enthusiastic in their preparations of nurses for potential media encounters. It is at this point the failure of nurses to seek out research findings must be addressed. Dissemination of research about whistleblowing will make nurses aware of the problems, the outcomes, and what they can do to report their concerns while keeping themselves safe.
- 4.** Universities that offer tertiary management degrees must include the subjects of public disclosure, advocacy and the labelling of nurses as whistleblowers to their curricula. It would seem logical that this information be presented within an ethics framework. Empowerment of managers with knowledge and research findings about professional responsibility and nurse advocacy will pave the path to open disclosure in healthcare.
- 5.** Area Health Services would benefit from review of the current policy mandate that *no one speaks to the media*. Adverse outcomes in health care are big news. Given the sheer numbers of nurses employed, the probability of one of them speaking to the media is real. It is important for Area Health Services to acknowledge this fact and, as for

any other risk element or activity, warn and prepare nurses to handle such a situation professionally and appropriately. One way of achieving this may be to include media awareness and escalation of concerns as part of the annual mandatory training required of all nurses.

This research reveals what nurses advocate for and what the media projects may be two very different things. Once a nurse has exhausted all other avenues of internal reporting, some issues will be significant enough to risk public declaration. It is professional naivety that sees nurses caught up in media storms - lost, unprotected and left wondering when the issue became about them. Nurses must be empowered with the skills and knowledge necessary to demonstrate escalation of the event with eloquent expression of the issue of concern. It takes a good deal of exposure and practice to deal with the media. The confidence to do so for nurses at least, can only come from universities and healthcare organisations that embrace open disclosure which is demonstrated by strategic media awareness training of staff. Forewarned is forearmed.

Labelling: Sticks and Stones may Break my Bones

Social reaction or labelling theory has evolved since 1938 (Wellford, 1975). Ewin Lemert is credited as the founder of societal reaction theory – a precursor to social reaction or labelling theory as is understood today. This theory usefully divides deviance into two subcategories, primary and secondary deviance. Primary deviance occurs when a person is labelled

because of perceived deviant or criminal behaviour, but the label is rejected by the person, who does not associate the label with themselves. The primary deviance status will remain as long as the person is capable of rationalising the label as having been incurred as part of a socially acceptable role (Lemert, 1951). Secondary deviance occurs when the person accepts the label as part of their self image.

Howard Becker in 1963 was hailed as the founder of modern labelling theory. Becker proposes society reacts to people specifically because of their labels, and a person may be known best by a specific label while other labels the person possesses are overlooked. This point was confirmed three decades later when Rothschild and Miethe (1999) described how whistleblowers who are considered to be at high risk of reoffending will be better known for their whistleblowing label than for the role from which they acquired the label in the first place.

Labels matter! Horley (2011) states labels or names affect us throughout our lives. The value appointed to the label influences what we believe we can and cannot do and what we should and should not think. Labels, essentially intangible, are pervasive influences on behaviour.

While labelling occurs in the school yard, in the workplace and in the home, there are 'certain social actors who are able to label with particular potency' (Horley, 2011, p. 127). Labels can be iatrogenic; and the accuracy of the label is irrelevant (Edens & Petrila, 2003). The impact of the label on the

individual is the issue. Edens, Colwell, Desforges, and Fernandez (2005) found when a person is labelled an incurable psychopath, jurors are more likely to recommend the death penalty even if the individual is a juvenile (Edens & Petrila, 2003). The label speaks louder than the action, achieving the desired outcome to sensationalise and stigmatise the person while devaluing and even losing the importance appointed to the reason the person was labelled in the first place.

Society needs people to speak out about organisational wrongdoing. Labelling nurses who advocate publicly for their patients as whistleblowers is an outrage, for reporting wrongdoing and patient safety concerns are within their area of authority (Near & Miceli, 1995). To enable nurses to be effective in communicating their concerns, organisational and educational change needs to be considered, planned and implemented.

The literature identifies two areas of whistleblowing research, identifying conditions under which an observer of wrongdoing will most likely report it, and the retaliation that results (Meithe & Rothschild, 1994; Near & Miceli, 1986).

This research supports three of Miceli and Near's (2002) four hypotheses of what make whistleblowing effective:

Hypothesis 1: Whistleblowing will be more effective when it is role prescribed.

Hypothesis 2: Whistleblowing will be more effective when whistleblowers experience lower levels of retaliation.

Hypothesis 3: When whistleblowers do not use channels external to the organisation, they are more effective when the wrongdoing is of lesser magnitude (pp. 459-450).

This research rejects the fourth and final hypothesis 'Whistleblowing will be more effective when whistleblowers who use internal channels report wrongdoing to complaint recipients of high status' (p. 450). Rejection of this hypothesis is based on the findings of this study and the literature (Ahern & McDonald, 2002; Dawson, 2000; Hunt & Shailer, 1995; Jos, 1991; Lennane, 1993) confirms nurses go to great lengths to raise their concerns via legitimate, internal reporting channels. The failure of managers to investigate claims by nurses is responsible for driving them and their allegations outside the organisation, where a media spotlight and a perpetual label awaits them.

Findings from this Research

This research finds labelling a nurse a whistleblower is a first step in causing damage to the nurse's professional reputation and reducing employment and career opportunities. The profound grief following loss of reputation and career path manifests itself as physical and psychological ill health, and is the legacy for the whistleblower nurse.

Labelling as a whistleblower, says P. Jackson (1999), is designed to discourage disclosure of facts about adverse events, outcomes or practices. The participants of this study have discovered the label 'whistleblower' and its punishments persist across the career span of the person who speaks out. The participant's experiences within this study have revealed a 'labelling for life phenomenon' otherwise described by Rothschild and Miethe (1999) as being denied career advancement and the acquisition of a lifetime ban from achieving another job in the chosen specialty. This statement is true for Kathrine, who because of her perceived propensity to speak out about standards, ethical practice and patient outcomes has achieved 'master status' (Rothschild & Miethe, 1999, p. 110) and is today defined as a whistleblower rather than as an experienced senior career nurse.

The participants of this study do not accept the label whistleblower. Rather, as mandated in The Code of Ethics for Nurses in Australia (Australian Nursing and Midwifery Council, 2008a) they see themselves as 'nurses who actively participated in minimising risks for individuals by supporting quality practice environments'. This Code confirms their 'authority to question and where necessary report to an appropriate authority in nursing and health care issues they consider on reasonable grounds to be unethical, unsafe or illegal' (p. 4). It is interesting to note a clear definition of 'an appropriate authority' is not offered. Declarations of concern by a nurse to a person who is thought to be an appropriate authority may well be considered an act of

whistleblowing under the Code of Ethics for Nurses in Australia. It would seem by limiting the definition of an appropriate authority to either nursing or healthcare, the code ensures any nurse who speaks out publicly will have overstepped the mark.

Strategies for Nurses Now and in the Future

Advocacy is not whistleblowing. Firstly, and most emphatically, nurses, nurse educators, nurse leaders, universities and Area Health Services must reject the label of whistleblower as appropriate for Australian nurses who speak out publicly about patient care and patient outcome concerns. There is a need to create role-specific language in the profession, rejecting the concept of whistleblowing in favour of advocacy. This research defines an Australian nurse advocate as: ‘...a nurse who raises moral, ethical, professional or practice standard concerns via internal then external channels, in response to threats to patient care/patient safety or in response to perceived organisational jeopardy’.

The findings of this research will be promoted in two ways. First, this thesis is destined to become a book which may be accepted as a prescribed text for healthcare students across the spectrum. Second, the information in this work will be used to lobby politicians and health policy decision makers to promote acceptance of the above definition of an Australian nurse advocate into the Codes of Conduct for nurses across Australia. By virtue of assimilation of this definition into the Codes of Conduct, other standards

such as The Code of Ethics for Nurses in Australia will be required to follow suit and provide consistency of definition and therefore legitimise the action of speaking out.

The acceptance of the definition of an Australian nurse advocate, the result of this research, will be strengthened if it is accepted in law. If it is unlawful to label nurses who meet the requirements of this definition as whistleblowers, the likelihood of continuation of that practice by the media would be drastically reduced. The appointment of severe fines for labelling nurses in such a manner would serve as a significant deterrent to the media and organisations alike.

When professional behaviour, opinion, standards, research and the law support the concept of the nurse advocate, the action of speaking out will be legitimised and respected. Promotion of the concept that nurse advocates are not whistleblowers will generate nursing theory regarding the acceptability of advocacy regardless of the level of escalation. Only when acceptance of nurse advocacy is achieved will nurses finally be able to advocate for their patients without fear of reprisal or punishment.

Career Protection: Creation of the Career Vantage of Safety

There is a plethora of information regarding professional retaliation against nurses who advocate publicly for their patients. Life-and career-changing consequences include deliberate role changes from the position held when

the allegations of whistleblowing were made (Einarsen et al., 2003; Quine, 2001; Simons, 2006). Making such a decision for change enables the nurse to find work in a different environment with different colleagues, but robs the organisation of the expertise and experience the nurse had acquired.

Marginalisation and isolation from the social group (Day et al., 2006) by colleagues contributes to extreme unhappiness for nurses who make public disclosures. This behaviour is deliberate and intended to foster an untenable work environment until the nurse is forced to resign (Fox & Stallworth, 2003).

What seems to be missing from the literature is any acknowledgement of the lengths to which nurses who have spoken out publicly must go in order to create and maintain a tolerable working environment. This research reveals the participants of this study all adopted survival strategies to allow for the continuation or not, of their professional lives after speaking out publicly.

This concept is defined in this research as the creation of a career vantage of safety for nurse advocates. In response to workplace bullying, they choose role change, job change or engagement in new nursing social groups in order to continue to work as a nurse. The different strategies adopted by the nurses enable them to act ethically and responsibly towards their patients, but with consideration for their own future protection as well. This concept of

the adoption of a career vantage of safety for nurses who have spoken out publicly has not been noted elsewhere.

Findings from this Research

The participants with the exception of Meadhbh confirmed they would again speak out publicly if their employers did not address patient safety or adverse outcome concerns. However, the experience of being labelled whistleblowers has left each nurse guarded and highly selective about what matters would be deserving of placing themselves again at risk of professional criticism, ostracism and vilification, as shown in Table 7. They realise, to continue to work as nurses, they must be discerning about what is worth the risk of public exposure, and more importantly how to ensure they remain safe in their respective careers while preserving their health, welfare and financial futures. This research confirms when the extreme levels of bullying described by Leymann (1990, 2006) were experienced by the nurses, their personal, strategic and organisational levels of trust were skewed and undermined (D. Jackson, 2008a; R. Robertson, 2005). While self-preservation tempers passion, the nurses confirm they remain ethically and professionally compelled to advocate for their patients; but they will remember and take into consideration their experience of being reviled as whistleblowers.

Table 7: Survival strategies of the participants of this study

Participant	Strategy to create a career vantage of safety
Meadhbh	Role change: To leave clinical nursing forever.
Yanaha	Role change: Works selectively with nominated surgeons – exclusive orthopaedic focus.
Monique	Role change: Works with a nursing agency. No longer works exclusively as an intensive care nurse.
Simone	Role change: Works exclusively in operating theatres where she will never again be left without a doctor to attend a patient.
Kathrine	Forced resignation and role change: Is unemployable as a manager by New South Wales Health. To fly under the radar, she works permanent night duty as a clinical midwife.
Violet	Forced resignation: Can no longer work in any capacity due to impaired professional self-confidence and fear.

Strategies for Nurses Now and in the Future

The way in which nurses are treated after speaking out is a reflection (or lack) of organisational transparency, values and culture. While this research shows nurses who speak out often change roles or leave their jobs to find work in less inimical environments, this is often an act of professional survival. The following are strategies to promote healthy organisational practices that may be more supportive of nurses who make public disclosures. The expectation of ethical behaviour by nurses is unrealistic if

Area Health Services are not transparently open and reactive to disclosures made by staff. The managers of organisations create the temperament of the workplace. If the internal and external structures of organisations provided avenues for address of employee concerns, the need to make public disclosures would be moot (Firtko & Jackson, 2005). Adoption of principles of ethical behaviour by the New South Wales Health Department (now NSW Ministry of Health) and its Area Health services that embrace a culture of disclosure is essential for the declaration of patient safety and adverse patient outcome concerns by nurses.

It is important for New South Wales Health and all other health care facilities to demonstrate measurable efforts to exemplify open disclosure within the Australian Council on Healthcare Standards (ACHS) EQuIP program – the accreditation process for health care facilities within the state. The functions, standards, criteria and elements of EQuIP (Australian Council on Healthcare Standards, 2007) when applied to disclosure policies and procedures would ensure health care organisations may no longer pay lip service to disclosure, but are required to demonstrate compliance with New South Wales Health disclosure policies. If organisations do not provide nurses with the opportunity to disclose, the nurses, by virtue of their inherent professional obligations, escalate their concerns to the point where public disclosure may be necessary. The adoption of values, policies and a culture of disclosure by

New South Wales Health and its organisations is vital if nurses are to be to be open and honest in their declarations of concern.

The following five recommendations are made to encourage willingness on the part of organisations to promote open disclosure and provide a path of reporting for nurses.

- 1.** Cultivation of a culture of reporting.
- 2.** Development of disclosure policies and protocols that are measureable within the accreditation of health care facilities process.
- 3.** Evidence of good governance.
- 4.** Training and support for local and senior managers who will be the recipients of reporting from staff.
- 5.** Mandatory training and support for all staff, to inform and demonstrate how appropriate reports are made with explanation of the escalation process should the concern not be addressed to the satisfaction of the reporter.

The value statement of New South Wales Health and its Area Health Services must demand and embrace a culture of disclosure. It will be necessary to review and amend the Australian Council on Healthcare Standards (ACHS) accreditation process to include the requirement by Area Health Services to demonstrate policies, procedures and processes that enable disclosures to be made by nurses. Similarly, this will be necessary for the promotion of evidence of the conduct of good governance by Area Health Services. Managers will require support and training to embrace a no-tolerance policy

to passivity, and to receive confidential disclosures. Managers must lead by example, valuing disclosures and promoting trust in the workplace. The importance of education and the promotion of free discussion that supports and rewards people who speak up is a way of making the staff/team part of the solution to the problem.

Mobbing: Retaliation against Nurse Whistleblowers

Wilmot (2000) points out the good that is intended by nurses who speak out to protect patients is often lost when the focus of the event is directed on the whistleblower. Wu (2000) also notes fear of reprisals, individual repercussions and blame are disincentives for nurses to report concerns. Fox and Stallworth (2003) assert whistleblowers 'who lose their jobs, and most importantly their health in the process are, as a result of speaking out, affected economically, physically and emotionally' (pp. 438-439) – an opinion shared by Bjorkqvist (2000) Einarsen (2000) and Cowie et al. (2002). The whistleblower becomes the focus of attention and the target for criticism, vilification, personal, economic and professional loss; the issue at hand is minimised or lost.

Workplace mobbing is described by Leymann (1996) as 'ganging up on... or psychologically terrorising' (p. 165) others at work. Chappell and Di Martino (2001) describe workplace mobbing as 'group psychological harassment' (p. 4). Mobbing behaviours are deliberate and include 'covert forms of rumour, gossip and innuendo used to discredit and demonise targeted co-workers

until they are forced to leave their employment' (Shallcross, Sheehan, & Ramsay, 2008, p. 56). The International Labour Organisation (ILO), a United Nations agency which promotes social justice and internationally recognised human and labour rights, identifies workplace violence as a labour issue of increasing worldwide concern, and has extended the definition of workplace violence to include psychological acts of aggression (Chappell & Di Martino, 2001). Research confirms psychological damage, post traumatic stress disorder, suicidal and homicidal reactions are the long-term results of mobbing (Groeblichhoff & Becker, 1996; Leymann, 1996).

There is a clear pattern in relation to workplace mobbing (Davenport, Distler-Schwartz, & Pursell-Elliott, 1999), with women at particular risk of being targeted by other women (Namie & Namie, 1999). According to Davenport et al. (1999), typically there are five stages of escalation in mobbing behaviours:

- 1.** Initial contact or critical incident stage
- 2.** Psychological abuse is directed at the target
- 3.** Management intervenes – often siding with the perpetrators
- 4.** Targeting and discrediting the worker as 'difficult or mentally ill'
- 5.** Expulsion of the target from their employment (p. 38)

At phase three, attacks change from co-worker verbal abuse to abuse of power by management over the staff they supervise. Mobbing behaviours can be seen across the global workforce and across all levels of employees –

from floor workers to supervisors and managers (Davenport et al., 1999; Einarsen et al., 2003; M. Lewis, 2001).

Di Martino, Hoel and Cooper (2003) confirm, unlike a number of European and Scandinavian countries, Australia does not have legislation in place that would enable lawful address of mobbing, covert behaviour and psychological aggression in the workplace (pp. 47-56). Shallcross et al.'s (2008) study of public service workers who identify themselves as targets of workplace mobbing suggests a legislative approach may be necessary to provide redress to targeted workers while deterring and preventing counterproductive behaviours from occurring in the first place (Bukspan, 2002). This will involve widening of the anti-discrimination legislation to include workplace bullying and mobbing to provide the Anti-Discrimination Commissions in the states and territories of Australia with a platform from which complaints can be heard (McCarthy, 2003). The Tasmanian Anti Discrimination Commissioner has already considered this option, and has recommended the legislation be amended to incorporate 'workplace bullying' as a generic term (p. 235). This inclusion is required for the New South Wales Anti-Discrimination legislation if the scope of the Act is to include and offer protection to nurses who advocate publicly.

The experiences of the participants of this study went beyond usual bullying and harassment tactics by the media and by colleagues. The nurses through first-hand experience have come to realise when the decision is made to

blow the whistle, regardless of the reason, there are immense personal and professional consequences for the individual. The nurses experienced ostracism, bullying and harassment (Hockley, 2000; M. Lewis, 2001; J. Madison & Minichiello, 2000); marginalisation (Leymann, 1990); and financial and social ruin (Fox & Stallworth, 2003) as consequences of speaking out. Martin and Rifkin (2004) list retaliatory consequences for whistleblowers as including organisational retribution, loss of social and peer support (Attree, 2007), pillorying, ostracism, humiliation and other exclusionary practices designed to marginalise the whistleblower (B. Berry, 2004; Faunce et al., 2004; Zipparo, 1999).

All the participants experienced five stages on Leymann's (1990) mobbing scale, from stigmatisation as being difficult, unethical or emotionally ill to being forced out of their positions as senior nurses. This research reflected Leymann's (1990, 1996, 2006) findings that lack of accurate understanding and support by employers precipitated the expulsion of six career nurses, triggering symptoms typical of post traumatic stress disorder, characterised by psychosomatic symptoms, depression and for some, the contemplation of suicide. The women all came to realise the impact of being labelled and punished as a whistleblower nurse is not limited to the professional persona, but insidiously encompasses the individual herself (Dellasega, 2009; Leymann, 1990; Raskauskas & Stoltz, 2004; Rys & Bear, 1997).

Strategies for Nurses Now and in the Future

In the first instance, the profession of nursing must undertake review of its behaviours and actions towards its members and acknowledge the bullying, mobbing behaviours that have long been a source of attrition from the workforce. In particular, newly qualified nurses must be educated about mobbing behaviours as, according to Berry, Gillespie, Gates and Schafer (2012), they are particularly vulnerable to increased absences, injuries, attrition and stress induced adverse patient safety events. It is timely for the nursing profession to recognise and acknowledge the significant role and consequences relational aggression (Dellasega, 2009) has in the way in which nurses communicate with each other. However, while raising of awareness of the issues of communication and the way in which nurses treat each other, only when the legislation acknowledges, values and protects nurses who advocate for their patients will reduction of mobbing behaviours within the profession be achieved (Shallcross et al., 2010).

It has been stated in the literature that legislative change is required to reduce workplace mobbing (Shallcross, 2003). However, Sheehan (2004) notes legislators to date have made no changes to legislation that would prohibit mobbing in the workplace. Likewise, the Zero Tolerance to Violence policy of the New South Wales Health Department has been found to be less than effective in the reduction of bullying within the nursing ranks (Sheehan, 2004). To date, it seems the Zero Tolerance to Bullying policy is lip service

paid to a retaliatory, horizontally and vertically violent, bullying profession that employs mobbing tactics against nurses who advocate for their patients and then condemns them as whistleblowers.

Latimer and Brown (2007) confirm Australia's nine jurisdictions have passed public sector whistleblowing legislation. The legislation is inconsistent, with few common tests across the jurisdictions, to the point where an employee in one state can make a protected disclosure but an employee in another state cannot. Ex-Prime Minister Kevin Rudd proposed introducing best practice federal whistleblowing legislation to address the shortcomings and inconsistencies in the individual legislations (Latimer & Brown, 2007), but this election promise has yet to come to fruition.

This research concurs with the literature that bullying, harassment and mobbing behaviours need not only to be recognised by the Australian judicial system. Legislation needs to be enacted which is effective in preventing them. Nurses who engage in bullying behaviours according to Matt 'are in violation of general ethical principles as well as ethical codes ... and may also be in violation of civil and criminal laws' (2012, p. 12). The acceptance of these terms in law is essential if reduction in workplace violence is to be achieved. It is the view of this researcher that there are four specific pieces of legislation that require amendment in this state: the NSW Occupational Health and Safety Legislation, NSW the Anti-Discrimination legislation, the Public Interest Disclosure policy directive by

the New South Wales Health Department and the Whistleblower Laws of New South Wales.

Australian Legislation: A Review

NSW Occupational Health and Safety Act 2000 No. 40

This Act, despite the plethora of information available in the literature, makes no specific reference to workplace violence, bullying and harassment in terms of threats to the health and welfare of a targeted worker. Division 3 point 23 of the Act under the heading 'Unlawful Dismissal or Other Victimization of Employee' (New South Wales Government, 2011) states:

An employer must not dismiss an employee, injure an employee in his or her employment or alter an employee's position to his or her detriment because the employee:

- a.** Makes a complaint about a workplace matter that the employee considers is not safe or is a risk to health.
- b.** Is a member of an OHS committee or an OHS representative.
- c.** Exercises any functions conferred on the employee under Division 2 which is the section which outlines the duty of the employer to consult (whether a member representative or otherwise). (pp. 13-14)

The risks defined in the Act relate specifically to the manner of conduct of work, the plant or substances used and the condition of the premises where the work is conducted.

As stated in the Act, the objects of this legislation are:

- a.** To secure and promote the health, safety and welfare of people at work.
- b.** To protect people at a place of work against risks to health or safety arising out of the activities of persons at work.
- c.** To promote a safe and healthy work environment for people at work that protects them from injury and illness and that is adapted to their physiological and psychological needs.
- d.** To provide for consultation and co-operation between employers and employees in achieving the objects of this Act.
- e.** To ensure that risks to health and safety at a place of work are identified, assessed and eliminated or controlled.
- f.** To develop and promote community awareness of occupational health and safety issues.
- g.** To provide a legislative framework that allows for progressively higher standards of occupational health and safety to take account of changes in technology and work practices.
- h.** To deal with the impact of particular classes or types of dangerous goods and plant at, and beyond, places of work. (p. 2)

This research and the literature indicate policies and practices that promote fairness and justice are necessary if mobbing is to be addressed in the

workplace (Shallcross et al., 2010). The current New South Wales Occupational Health and Safety Act – 2000 No. 40 is an example of legislation that is not legally enforceable by virtue of omission of defined terms such as whistleblower, bullying, harassment and workplace mobbing. O’Sullivan (2005) observes morally and ethically questionable behaviours are exempt from the legislation, based on the assumption of reasonable action by management.

While psychological injuries are indisputable, compensation for injuries is based subjectively on what is considered to be reasonable action by management (or not) (Calvey & Jansz, 2005). This research and the literature (Shallcross et al., 2010) assert the inclusion of the reasonable management action clause effectively condones workplace mobbing behaviours. While Codes of Conduct, policies and directives define unacceptable behaviour for the worker, there is little evidence of any degree of protection under the Occupational Health and Safety Act – 2000 No. 40 for nurses who speak out publicly.

New South Wales Anti-Discrimination Legislation

The lack of formal acknowledgement of bullying, harassment and mobbing behaviours in the workplace renders the New South Wales Anti-Discrimination Act (1977) legislation inadequate in terms of whistleblowers being able to make any sort of appeal about being victimised in the workplace. Under the Act, victimisation is limited to the following criteria:

- a.** age
- b.** carer's responsibilities
- c.** disability
- d.** homosexuality
- e.** marital or domestic status
- f.** race
- g.** sex
- h.** pregnancy
- i.** transgender

The New South Wales Anti-Discrimination Board states that a person may be considered to have been treated unfairly if, in response to the above criteria, the following reactions have resulted:

- a.** harassment
- b.** demotion
- c.** dismissal
- d.** banning from a store or registered club
- e.** eviction from accommodation
- f.** expulsion from school or university

This legislation is inadequate, as there is no acknowledgement of acts of discrimination made against other whistleblowers or nurses who advocate publicly for their patients. The highly prescriptive nature of the wording of the Act is remiss in the exclusion of workers who, through bullying,

harassing and mobbing behaviours, suffer discriminatory actions and reprisals.

New South Wales Public Interest Disclosures

In September 2011, New South Wales Health released its Public Interest Disclosures policy directive (2010). While this document should provide reassurance and support for nurses who speak out publicly, the scope of the directive does not cover public declarations by nurses concerning patient care. This document provides:

procedures for receiving, assessing and managing public interest disclosures in compliance with 2011 amendments to the Protected Disclosures legislation, now titled the Public Interest Disclosures Act of 1994. This policy is intended to ensure that reports of wrongdoing related to corruption, serious and substantial waste, maladministration and government information contravention are treated appropriately and that staff who make reports based on these criteria will be protected from reprisal (Corporate Governance Unit, 2011, p. 1).

The Public Interest Disclosures policy directive by the NSW Health Department will not protect nurses who advocate publicly for their patients; for their arena of reporting falls outside the scope of the directive.

A review of New South Wales Occupational Health and Safety legislation, Anti-Discrimination legislation and Public Interest Disclosures policy directive confirms the phenomenon of mobbing is not formally recognised, understood or legislated for outside Europe or Scandinavia (Chappell & Di Martino,

2001). Shallcross, Ramsay and Barker's study (2008) finds 'the absence of specific legislation to address workplace mobbing maintains a system that effectively denies justice and legal remedies to those targeted' (p. 11). Only when a New South Wales legislative framework is introduced in which mobbing is acknowledged as a significant problem in the workplace will nurses be able to advocate for their patients publicly without the fear of reprisal.

Whistleblower Laws in Australia

Whistleblower Laws in Australia it seems offer little if any protection to nurses who speak out publicly. The conjecture of Sawyer et al. (2006) that 'the negative correlation of the pragmatic legitimacies of the organisation and the whistleblower ensures whistleblower laws are difficult to enforce' (p. 14) has been proven first-hand by all the nurses involved in this research being named and punished as whistleblowers without ever being charged. A governmental release by Ludwig (2010) confirmed the need to amend Whistleblower Laws, acknowledging 'matters that not only threaten immediate and serious harm to public health and safety, but also matters relating to corruption, maladministration, wastage of public funds and official misconduct, may also (now) be disclosed to third parties, including the media' (p. 1). It proposed that changes be implemented within 2010. To date those recommendations have not been adopted.

L. Fields (2010) interviewed Cynthia Kardell, the National Secretary of Whistleblowers Australia, who denounced New South Wales' intended changes to whistleblower laws because the penalties imposed are not severe enough to stop corruption and malpractice in the public sector: 'the measures are insufficient given the likelihood of the State, through the Department of Public Prosecutions, criminally prosecuting one of their own is not very high' (p. 1). She pointed out that since whistleblower legislation came into being 'to date, no person has successfully been criminally prosecuted in NSW for reprisal action taken against a whistleblower' (2010, p. 1). L. Fields also quoted Dr A J Cook, senior lecturer at Griffith Law School: 'The laws will make a difference, clearly NSW is still languishing behind national and international best laws in this area and have done so for some time' (p. 1). Until there are enforceable laws with severe penalties to be enacted against persons and organisations that retaliate against whistleblowers, the truth will always come at the cost of the life and the livelihood of the person who has spoken out publicly.

Studies Recommended for the Future

Creation of a career vantage of safety

What lessons can be learned from nurses who continue to work in the profession of nursing after being labelled whistleblowers?

This research confirms nurses who have been labelled whistleblowers make deliberate decisions regarding role, practice and even whether to continue to

work as a nurse after the whistleblowing event. The six nurses involved in this study all made calculated changes in order to consider working as a nurse in the future. This subject is worthy of further academic inquiry, to establish if all nurses who are labelled whistleblowers must alter their working roles if they are to continue work as nurse, and to determine what lengths they must go to or changes they must make in order to continue to work safely within the profession.

Do Australian nurses experience greater reprisals as a result of the Australian cultural tenet 'you don't dob in a mate' than nurses in other countries?

In Australia, the concept of mateship is a legacy of convict settlement and part of the Australian psyche. The colloquial term 'you don't dob in a mate' (Catanzariti, 1998) heavily influences the Australian work ethic. The canon of mateship is absolute, with the expectation that workers do not 'dob' to management for any reason. Another tenet of the Australian work ethic is that organisations will display moral legitimacy and 'do the right thing' (Sawyer et al., 2006, p. 4). If mateship, camaraderie and transparency of moral behaviour by organisations, combined with a cultural aversion to 'dobbers' (Fong, 1998, p. 9) are expectations of workers, does the act of public disclosure exact harsher reactions and punishments for Australian whistleblowers? The question of the effect of Australian cultural ethics and the links with whistleblower issues exceeds the scope of this study, but the question is worthy of further academic inquiry.

Protocols and Safeguards for Researchers Undertaking Sensitive Research

The responsibility to inform and warn

Conducting sensitive research, claim Kidd and Finlayson (2006), using a term coined by Barker and Buchanan-Parker (2005), is like 'negotiating a course through deep water, some of which is familiar and charted and some that is unknown and potentially treacherous for both the researcher and the participants' (p. 424). This is also held by R. Lee and Renzetti (1990), who state sensitive research poses considerable threat to the researcher and the participants by heightening awareness of ethical dilemmas. The requirements for undertaking ethical research in terms of protection of the participants are well documented: such as maintaining anonymity by the employment of nom de plumes and the requirements of confidentiality (Aita & Richer, 2005), informed consent (Kidd & Finlayson, 2006) and promotion of ethical balance between the conduct of appropriate research that is mindful and respectful of the rights of the participants (Aita & Richer, 2005; Begley, 2005; Doane, 2002). There is, however, less documentation concerning protection of the researcher from exposure to sensitive subject matter during the conduct of the study. Generalised ethical guidelines concerning the researcher and the participants do not provide solutions to specific ethical conundrums or dilemmas (Halse & Honey, 2005).

The findings of this study do not concur with the view of Corbin and Morse (2003) who suggested the potential harm to participants derived through in-

depth interviewing (Minichiello et al., 1996) is overstated and no more extreme than is everyday life. In recognition of the unpredictability of human inquiry, Kidd and Finlayson (2006) state the researcher is endowed with the responsibility of ensuring the participants are informed of the expectations and possible impacts the research may have on them by 'an ethically robust recruitment and informed consent process that will provide a platform for negotiating ethically uncharted waters' (p. 427). The conduct of this study confirms the researcher has a responsibility to warn participants who are involved in sensitive research that resurrected memories may cause discomfort, sadness and invoke acute anxiety.

Researcher vulnerability

In recognition of the risk to researchers who undertake sensitive research, this study accepts the recommendations by Dickson-Swift, James, Kippen and Liamputtong (2008) for professional supervision, policy development and minimum training standards for researchers to protect them from harm when undertaking qualitative interviews.

- 1.** It is important that the researcher consider the risks when planning to undertake sensitive research. The potential risks should be outlined when the initial application to undertake research is submitted to the university.
- 2.** It is recommended the Human Research Ethics Committees (HREC) as well as university department heads via supervisors should

receive regular feedback to ensure the researcher's wellbeing and safety when sensitive research is being conducted.

- 3.** Researchers should regularly perform risk assessments of the their study to ensure they adhere to the ethical principle 'to do no harm.' This assessment must include review of researcher reactions to narratives or participant behaviour.
- 4.** Researchers are advised to have a debrief strategy involving a qualified counsellor if there is a need to discuss feelings following the conduct of interviews.

Strategies for protecting transcriptionists

Dickson-Swift et al. (2008, p. 140) cite Gregory et al. (1997) to confirm transcription of sensitive data by a person outside of the research has the ability to upset or impact upon the emotional health of the transcriptionist. The following recommendations were made to minimise the risk to transcriptionists with suggestions transcriptionists should:

- a.** Be included in the ethical clearance process;
- b.** Be informed of the nature of the research and the type of data;
- c.** Be alerted before the transcription of potentially challenging and difficult interviews;
- d.** Have regularly scheduled debriefing sessions;
- e.** Have prompt access to an appropriate person for crisis counselling;
- f.** Have a clearly documented termination from the transcription process that includes a resolution of personal issues that arose as a consequence of the work; and

- g.** Be encouraged to journal their thoughts and feelings which may then become part of the fieldwork notes in some research approaches (pp. 294-300).

Recommendations for Universities

This research supports four of the seven recommendations made by Bloor, Fincham and Sampson (2010, p. 52) as cited in the Quality (NCRM) Commissioned Inquiry into the risk of wellbeing of researchers in qualitative research (Bloor, Fincham, & Sampson, 2007), to minimise risk to researchers:

- a.** Postgraduate research methods courses should include researcher safety in their curricula.
- b.** All university departments should be subject to periodic health and safety audits, including confirmation of strategies and provision for researcher safety.
- c.** All funders should require principal investigators to comply with Social Research Association (2004) (or equivalent) safety guidelines.
- d.** All university ethics committees should accept formal responsibility for oversight of postgraduate student safety.

Conclusion

This study concludes the catalyst for the consequences of whistleblowing are attributable to labelling by the media and are synonymous with mobbing – the most severe form of bullying and harassment in the workplace, characterised by physical, emotional, and psychiatric disease and suicidal tendencies. To be considered a whistleblower in New South Wales is a death

sentence to career advancement and tenure. It is highly likely the professional ramifications will follow the nurse for the rest of her career, and may be applicable Australia-wide.

The nurses of this study, although labelled whistleblowers, vehemently reject the term, as their motivation for speaking out publicly was directly attributable to their inherent, professional role as patient advocates and 'doing their job'. This research defines an Australian nurse advocate as a nurse who raises concerns of a moral, ethical, professional or practice standards nature via internal or external channels in response to perceived patient care and organisational jeopardy. The expectation, indeed mandate that nurses will advocate for their patients can create an untenable position for the nurse. If nurses, because of patient deterioration, poor clinical practice or lack of availability of medical assistance, are required to work outside what would be defined as a reasonable scope of practice for their level of training and experience, in order to advocate for the patient, they risk their professional reputations, their livelihoods and their health. The nurses of this study with the exception of Meadhbh agree they would again speak out publicly, but add the proviso they would be much more selective in the matters in which they involve themselves. An important finding in this research has been that the nurses who continued to work within the profession, in hostile workplaces have created career vantages of safety. This protectionist reaction to their workplaces allows them to continue to

work as advocator nurses while choosing their battles carefully and importantly, protecting themselves.

The Occupational Health and Safety Laws (2011), the Anti-Discrimination Laws (1977) and the Protected Disclosure policy directive (New South Wales Government, 2010) of New South Wales Department of Health offer little if any protection to nurses who speak out publicly. Recent changes to Whistleblower Laws will not prevent reprisals against whistleblowers; for previous imposition of criminal penalties and fines against perpetrator organisations have never been upheld in the Australian legal system. The concept of disclosure in terms of patient advocacy is missing from all legislation in Australia. In order for nurses to advocate openly for their patients, they must demand change by New South Wales Health in its acknowledgement and treatment of nurses who speak out publicly. The irony is, if lawful protection of public disclosures by nurses were enacted, organisations would be more reactive to declarations, which in turn would greatly reduce the need for public declaration.

Researchers undertaking sensitive inquiries are at significant risk of physical and psychiatric conditions from exposure to extreme emotions and upsetting experiences. Participant observers are particularly at risk as they have already lived an experience which may be resurrected upon hearing similar stories from others. Researchers who undertake sensitive studies require support and protection by their universities, who should promote

occupational health and safety and ensure ethics committees and supervisors are trained in the conduct of sensitive research. Understanding the lived experiences of others can provide insight into human experience and human emotions. While that inevitably will impact upon the researcher, and particularly on a participant observer, it is important in seeking the truth the researcher and supervisors ensure the scope of the study is not influenced by the emotional impact of the data but remains true to the intent of the research.

This research finds the nurses who participated in this study are not whistleblowers. They are professional nurse advocates who, in the conduct of patient care, were subjected to career loss and significant health consequences in response to exposing poor clinical practice, adverse patient outcomes and deception. The lives of all the participants have forever changed. Due to their strength and candour, this story of what it is to be labelled a whistleblower nurse has been told. This research experience challenges the label 'whistleblower nurse' as professionally reprehensible and inappropriate. Nurses who advocate for patients are performing the expected role of a professional nurse; therefore, they are undeserving of the label and of the punishments that are imposed as reprisals against whistleblowers.

Postscriptum:

Catharsis

*Seeking to forget makes exile all the longer; the secret to redemption lies in remembrance.
-Richard von Weizaecker*

The collection of this research data as a participant observer was compelling, enraging and terrifying. I relived my own story repeatedly as I heard the narratives of women whom I have known and respected for many years. The experience was life altering. The moment the words began to flow, life once again sparked in that damaged part of my soul long sequestered and deliberately ignored in protection of myself. My survival strategies crumbled as my rage at the injustices meted out to each of us was resurrected, bringing with it a flood of the fear I have battled for years.

I have forgiven Narissa for misrepresenting me in the media; for despite using us to garner media attention, she too was a nurse advocate. I have forgiven New South Wales Health for robbing me of my career. But I will never forget what was done to me for telling the truth. To not forgive is to risk erosion of my soul with anger, bitterness and regret. Now that this thesis is written, I realise that by facing the spoken truths of my colleagues, I can do nothing about the past, but I can do something about the future for nurses and their ability to speak out. I now have the intellectual and

emotional skills to bring pressure to bear on politicians and law makers, to address the inadequate, inconsistent Occupational Health and Safety, Anti-Discrimination Protected Disclosure and Whistleblower laws of the state of New South Wales. I still feel the fear, but I am no longer afraid. I am proud of the commitment that I offer to my patients. I intend to take my place in academia to utilise the experience and knowledge I have gained in almost four decades of nursing experience plus this research, to empower nurses to advocate for their patients while protecting themselves. I now move on to the next stage of my life: older, wiser and grateful that I have survived.

References

- Adams, R. (2006). *The theory of virtue: excellence in being for the good*. New York: Oxford University Press.
- Ahern, K., & McDonald, S. (2002). The beliefs of nurses who were involved in a whistleblowing event. *Journal of Advanced Nursing* 38(3), 303-309.
- Aikens, C. (1937). *Studies in ethics for nurses*. Philadelphia: W.B.Saunders.
- Aita, M., & Richer, M. (2005). Essentials of health research ethics for healthcare professionals. *Nursing and Health Sciences*, 7(2), 119-125.
- Ajzen, I., & Fishbein, M. (1980). *Understanding attitudes and predicting social behaviour*. New Jersey: United States of America: Prentice-Hall.
- Alex, L., & Hammarstrom, A. (2008). Shift in power during an interview situation: methodological reflections inspired by Foucault and Bourdieu. *Nursing Inquiry*, 15(2), 169-176.
- Alimov, R., & Ponamarera, V. (2005). Russian nuke whistleblower files for asylum in Finland. Retrieved from http://www.bellona.org/english_import_area/international/russia/environments/info_access/40553
- Annas, G., & Healey, J. (1974). The patient rights advocate. *Journal of Nursing Administration*, 4(3), 25-31.
- Annells, M. (1996). Hermeneutic phenomenology: philosophical perspectives and current use in nursing research. *Journal of Advanced Nursing*, 23(4), 705-713.

- Aquino, K., & Thau, S. (2009). Workplace victimisation: aggression from the target's perspective. *The Annual Review of Psychology, 60*(1), 717-741.
- Ashforth, B. (1997). Petty tyranny in organisations: a preliminary examination of antecedents and consequences. *Canadian Journal of Administrative Science, 14*(2), 116-140.
- Ashforth, S., & Humphrey, R. (1995). *Labelling processes in the organisation: constructing the individual*. Connecticut JAI Press.
- Attree, M. (2007). Factors influencing nurses' decisions to raise concerns about care quality. *Journal of Nursing Management, 15*(4), 392-402.
- Australian Bureau of Statistics. (2010a). Australian demographic statistics. Retrieved from <http://www.abs.gov.au/AUSSTATS/abs@.nsf/Lookup/3101.0Main+Features1Jun%202010>
- Australian Bureau of Statistics. (2010b). Population characteristics, Aboriginal and Torres Strait Islander Australians 2006. Retrieved from <http://www.abs.gov.au/ausstats/abs@.nsf/mf/4713.0>
- Australian Council on Healthcare Standards. (2007). About EQUiP. Retrieved from <http://www.achs.org.au/equip4/>
- Australian Department of Foreign Affairs and Trade. (2007). About Australia: Australia's system of government. Retrieved from http://www.dfat.gov.au/facts/sys_gov.html
- Australian Institute of Health and Welfare. (2006a). Australia's health 2006. Retrieved from www.aihw.gov.au/WorkArea/DownloadAsset.aspx?id=6442453674

- Australian Institute of Health and Welfare. (2006b). Nursing and Midwifery Labour Force 2004. Retrieved from <http://www.aihw.gov.au/publication-detail/?id=6442467932>
- Australian Institute of Health and Welfare. (2008). Australia's health 2008. Retrieved from www.aihw.gov.au/publication-detail/?id=6442468102
- Australian Nursing and Midwifery Council. (2005). *ANMC national competency standards for the enrolled nurse*. Dickson: Australia: Australian Nursing and Midwifery Council.
- Australian Nursing and Midwifery Council. (2008a). Code of ethics for nurses in Australia. Retrieved from <http://equals.net.au/pdf/Code%20of%20ethics%20index.pdf>
- Australian Nursing and Midwifery Council. (2008b). *Code of professional conduct for nurses in Australia*. Dickson ACT: Australian Nursing and Midwifery Council.
- Australian Nursing Federation. (2005). Competency standards for the advanced enrolled nurse. Retrieved from http://www.anf.org.au/pdf/Competency_Standards.pdf
- Australian Nursing Federation. (2007). Nursing education: enrolled nurse. Retrieved from www.anf.org.au/pdf/policies/P_Nursing_education_EN.pdf
- Balsom, S. (1999). *Murder by media: death of democracy in Australia*. Brisbane: Interactive Presentations.
- Baly, M. (1986). *Florence Nightingale and the nursing legacy*. London: Croom Helm.

- Barker, P., & Buchanan-Parker, P. (2005). *The tidal model: a guide for mental health professionals*. Hove East Sussex: Routledge.
- Barnum, B. (1998). Nursing: the care ideologies *In Nursing Theory: analysis, application, evaluation 5th edn*. Philadelphia: Lippincott
- Barraud, A. (Writer). (2006). Whistleblowers and the law [Radio]. In A. Barraud (Producer), *The Law Report*. Australia: Australian Broadcasting Commission.
- Barry, M. (1988). Ethical considerations of human investigation in developing countries. *New England Journal of Medicine*, 319(16), 1083-1086.
- Bateson, G. (1972). *Steps to an ecology of mind*. New York: Ballantine.
- Beauchamp, T. (2008). The principle of beneficence in applied ethics. *The Stanford Encyclopedia of Philosophy - Fall 2008 edition* Retrieved from <http://plato.stanford.edu/archives/fall2008/entries/principle-beneficence/>
- Beauchamp, T., & Childress, J. (1994). *Principles of biomedical ethics 4th edition*. New York United States of America: Oxford University Press.
- Begley, A. (2005). Practising virtue: a challenge to the view that a virtue centred approach to ethics lacks practical content. *Nursing Ethics*, 12(6), 622-637.
- Benner, P. (1982). From novice to expert. *American Journal of Nursing*, 82(3), 402-407.
- Benner, P. (1991). The role of experience, narrative and community in skilled ethical comportment. *Advances in Nursing Science*, 14(2), 1-20.

- Benner, P. (1994). *From novice to expert: excellence and power in clinical nursing*. Menlow Park: Addison-Wilson.
- Benner, P. (2000). The roles of embodiment, emotion and lifeworld for rationality and agency in nursing practice. *Nursing Philosophy, 1*(1), 5-19.
- Berry, B. (2004). Organisational culture; a framework and strategies for facilitating employee whistleblowing. *Journal of Employee Responsibilities and Rights, 16*(1), 1-11.
- Berry, P., Gillespie, G., Gates, D., & Schafer, J. (2012). Novice nurse productivity following workplace bullying. *Journal of Nursing Scholarship, 44*(1), 80-87.
- Beyea, S. (2005). Patient advocacy: nurses keeping patients safe. *Association of Operating Room Nurses, 81*(5), 1046.
- Bjorkqvist, K. (2000). Social defeat as a stressor in humans. *Psychology and Humans, 73*(3), 435-442.
- Black, J. (2004). Blind obedience or plain stupidity? *Plastics Surgical Nursing, 24*(2), 37.
- Blackhall, L., Murphy, S., & Frank, G. (1995). Ethnicity and attitudes towards patient autonomy. *JAMA, 274*(10), 820-825.
- Bloor, M., Fincham, B., & Sampson, H. (2007). *Qualiti (NCRM) Commissioned Inquiry into the risk of wellbeing of researchers in qualitative research*. Cardiff: Cardiff University Retrieved from www.sussex.ac.uk/lps/research/.../ethicalguidelinesresearchgovernanc

- Bloor, M., Fincham, B., & Sampson, H. (2010). Unprepared for the worst: risks of harm for qualitative researchers. *Methological Innovations Online* 5(1), 44-55.
- Blumer, H. (1969). *Symbolic interactionism: perspective and method*. Edgewood Cliffs - New Jersey: Prentice Hall.
- Bolino, M., & Turnley, W. (2003). Counter normative impression management, likeability and performance ratings: the use of intimidation in organisational settings. *Journal of Organisational Behaviour*, 24(2), 237-250.
- Bolsin, S., Faunce, T., & Oakley, J. (2005). Practical virtue ethics: healthcare whistleblowing and portable digital technology. *Journal of Medical Ethics*, 31(10), 612-618.
- Borbasi, S., Jackson, D., & Wilkes, L. (2005). Fieldwork in nursing research: positionality, practicalities and predicaments. *Journal of Advanced Nursing*, 51(5), 493-501.
- Bowden, P. (2000). An 'ethic of care' in clinical settings: encompassing 'feminine and feminist' perspectives. *Nursing Philosophy*, 1(1), 36-49.
- Bradshaw, A. (2000). Competence and British nursing: a view from history. *Journal of Clinical Nursing*, 9(3), 321-329.
- Brouneus, K. (2010). The trauma of truth telling: effects of witnessing in Rwandan Gacaca Courts on psychological health. *Journal of Conflict Resolution*, 54(3), 408-437.
- Brown, A. (2006, November). *Public interest disclosure legislation in Australia: towards the next generation. An issues paper*. Paper

presented at the Australian Research Council 'Linkage' Project 'Whistling While They Work'. Canberra.

Brown, A., Latimer, P., McMillian, J., & Wheeler, C. (Eds.). (2007). *Best practice whistleblowing legislation for the public sector: the key principles*. Canberra: Australian Commonwealth Government.

Brownson, K., & Harriman, R. (2001). Recruiting staff in this era of shortage. *The Health Care Manager, 19*(4), 13-22.

Bukspan, E. (2002, 23-24 September). *The new law regarding bullying at work and its consequences in the French public sector*. Paper presented at the International Workplace Bullying Conference, London.

Burr, G. (1996). Unfinished business: interviewing family members of critically ill patients. *Nursing Inquiry, 3*(3), 172-177.

Calvey, J., & Jansz, J. (2005). Women's experience of the workers compensation system. *Australian Journal of Social Issues, 40*(2), 285-312.

Carrese, J., & Rhodes, L. (1995). Western bioethics on the Navajo reservation: harm or benefit? *JAMA, 274*(10), 820-825.

Catanzariti, J. (1998, May 30-31). Dobbers dilemma, a double-edged sword, *Weekend Australian*, p. 33.

Chafey, K., Rhea, L., Shannon, A., & Spencer, S. (1998). Characterisations of advocacy by practicing nurses. *Journal of Professional Nursing, 14*(6), 43-52.

Chappell, D., & Di Martino, V. (2001). *Global workplace violence 2nd edition*. Geneva: International Labour Office 2000.

- Charon, J. (2007). *Symbolic interactionism: an introduction, an interpretation, an integration*. Upper Saddle River - New Jersey: Pearson, Prentice Hall.
- Chiasson, M., Johnson, M., & Byington, J. (1995). Blowing the whistle: accountants in industry. *CPA Journal*, 65(2), 24-27.
- Christensen, M., & Hewitt-Taylor, J. (2006). Empowerment in nursing: paternalism or maternalism? *British Journal of Nursing*, 15(13), 695-699.
- Cloyes, K. (2002). Agonizing care: care ethics, agonistic feminism and a political theory of care. *Nursing Inquiry*, 9(3), 203-214.
- Coffee-Love, M. (2001). Said another way. The nursing shortage: what is your role? *Nursing Forum*, 36(2), 29-35.
- Cohen, B. (1963). *The press and foreign policy*. Princeton: New Jersey: Princeton University Press.
- Cook, C. (2003). The many faces of diversity: overview and summary. *American Nurses Association*, 8(1), 89-97.
- Corbin, J., & Morse, J. (2003). The unstructured interactive interview: issues of reciprocity and risks when dealing with sensitive topics. *Qualitative Inquiry*, 9(3), 335-354.
- Corporate Governance Unit. (2011). Public interest disclosures. In New South Wales Department of Health (Ed.), *PD2011_061* (pp. 24). Sydney: New South Wales Health.
- Cortina, L., & Magley, V. (2003). Raising voice, risking retaliation: events following interpersonal mistreatment in the workplace. *Journal of Occupational Health Psychology*, 8(4), 247-265.

- Coulter, C. (2005). Reflections from the field: a girl's initiation ceremony in Northern Sierra Leone. *Anthropological Quarterly*, 78(2), 431-442.
- Cowie, H., Naylor, P., Rivers, I., Smith, P., & Pereria, B. (2002). Measuring workplace bullying. *Aggression and Violent Behaviour*, 7(1), 33-51.
- Cowles, K. (1988). Issues in qualitative research on sensitive subjects. *Western Journal of Nursing Research*, 10(2), 163-170.
- Coyle, A., & Wright, C. (1996). Using the counselling interview to collect research data on sensitive topics. *Journal of Health Psychology*, 1(4), 431-440.
- Coyne, I., Chong, P., Seigne, E., & Randall, P. (2003). Self and peer nominations of bullying: an analysis of incident rates, individual differences and perceptions of the working environment. *European Journal of Work and Organisational Psychology*, 12(3), 209-228.
- Crist, J., & Tanner, C. (2003). Interpretation/analysis methods in Hermeneutic interpretive phenomenology. *Nursing Research*, 52(3), 202-205.
- Daiski, I. (2004). Changing nurse's disempowering relationship patterns. *Journal of Advanced Nursing* 48(1), 43-50.
- Dane, F. (1990). *Research methods*. California: Brooks/Cole Publishing Company.
- Daum, A. (1993). Cohesion vs. collusion: maintaining group direction. *Journal of Nursing Management*, 24(11), 90-92.
- Davenport, N., Distler-Schwartz, R., & Pursell-Elliott, G. (1999). *Mobbing: emotional abuse in the American workplace*. Iowa: Civil Society Publishing.

- Davies, A., & Harre, R. (1990). Positioning: the discursive production of selves. *Journal for the Theory of Social Behaviour*, 20(1), 43-63.
- Davis, A. (1990). Ethical similarities internationally. *Western Journal of Nursing Research*, 12(5), 685-688.
- Davis, D., & Konishi, E. (2007). Whistleblowing in Japan. *Nursing Ethics*, 14(2), 194-202.
- Dawson, S. (2000). Whistleblowing: a broad definition and some issues for Australia: published as a working paper. Melbourne Australia: Swinburne University of Technology.
- Day, G., Minichiello, V., & Madison, J. (2006). Nursing morale: what does the literature reveal? *Australian Health Review*, 30(4), 516-524.
- De Maria, W. (2002, 2-3 April). *Common law - common mistakes. The dismal failure of whistleblower laws in Australia, New Zealand, South Africa, Ireland and the United Kingdom*. Paper presented at the International Whistleblowers Conference, Indiana.
- De Maria, W., & Jan, C. (1994a). Queensland whistleblower study: unshielding the shadow culture. Brisbane Australia: Department of Social Work and Social Policy St Lucia Campus University of Queensland.
- De Maria, W., & Jan, C. (1994b). Queensland whistleblower study: wounded workers. Brisbane Australia: St Lucia Campus, University of Queensland. Department of Social Work and Social Policy.
- De Maria, W., & Jan, C. (1997). Eating it's own: the whistleblower's organisation in vendetta mode. *Australian Journal of Social Issues*, 32(2), 37-59.

- Deans, C. (2004). Who cares for nurses? The lived experiences of workplace aggression. *Collegian, 11*(1), 32-36.
- Dearling, J., & Rogers, E. (1996). *Agenda setting (communication concepts)*. Thousand Oaks: Sage.
- Dellasega, C. (2009). Bullying among nurses. *American Journal of Nursing, 109*(1), 52-58.
- Dempster, Q. (1997). *Whistleblowers*. Sydney Australia: ABC Books.
- Dempster, Q. (2002, 6th August). *Whistleblowing: Betrayal or public duty? The role of the media and NGO's*. Paper presented at the Whistleblowing conference, Sydney.
- Denzin, N. (1978). *Sociological methods*. New York: McGraw Hill.
- Denzin, N., & Lincoln, Y. (Eds.). (2011). *The Sage handbook of qualitative research*. Thousand Oaks California: Sage Publications Inc.
- Di Martino, V., Hoel, H., & Cooper, C. (2003). *Preventing violence and harassment in the workplace*. Luxembourg: Office for Official Publications for European Communities.
- Dickson-Swift, V., James, E., Kippen, S., & Liamputtong, P. (2006). Blurring the boundaries in qualitative health research on sensitive topics. *Qualitative Health Research, 16*(6), 853-871.
- Dickson-Swift, V., James, E., Kippen, S., & Liamputtong, P. (2008). Risk to researchers in qualitative research on sensitive topics: issues and strategies. *Qualitative Health Research, 18*(1), 133-144.

- Diekemper, M., SmithBattle, L., & Drake, M. (1999). Bringing the population into focus: a natural development in community health nursing practice. Part 1. *Public Health Nursing, 16*(1), 3-10.
- Dilek, Y., & Aytolan, Y. (2008). Development and psychometric evaluation of workplace psychologically violent behaviours instrument. *Journal of Clinical Nursing, 17*(10), 1361-1370.
- Doane, G. (2002). Am I still ethical? the socially mediated process of nurses' moral identity. *Nursing Ethics, 9*(6), 623-635.
- Duffin, C. (2001). Don't shoot the messenger. *Nursing Standard, 15*(52), 13.
- Duffy, K., McCallum, J., Ness, V., & Price, L. (2012). Whistleblowing and student nurses - are we asking too much? *Nurse Education in Practice, 12*(4), 177-178.
- Dugan, A. (1970). Nursing autonomy: key to quality nurturance. *Hospital Progress, 51*(4), 47-49.
- Eagly, A., & Chaiken, S. (1993). *The psychology of attitudes*. New York: Harcourt Brace Jovanovich.
- Eaton, T., & Akers, M. (2007). Whistleblowing and good governance. Policies for universities, government entities and nonprofit organisations. *The CPA Journal 77*(6), 66-71.
- Edens, J., Colwell, L., Desforges, D., & Fernandez, K. (2005). The impact of mental health evidence on support for capital punishment: are defendants labelled psychopathic considered more deserving of death? *Behavioural Sciences and the Law, 23*(5), 603-625.
- Edens, J., & Petrila, J. (2003). *Legal and ethical issues in the assessment and treatment of psychotherapy*. New York: Guilford.

- Edwards, M. (Producer). (2008, 5th December). Growing prescription abuse warrants investigation. *PM*. [Transcript] Retrieved from www.abc.net.au/pm/content/2008/s2439361.htm
- Einarsen, S. (2000). Harassment and bullying at work: a review of the Scandinavian approach. *Aggression and Violent Behaviour, 5*(4), 379-401.
- Einarsen, S., Hoel, H., Zapf, D., & Cooper, C. (Eds.). (2003). *The concept of bullying at work: the European tradition*. New York: Taylor and Francis.
- Einarsen, S., Matthiesen, S., & Skogstad, A. (1998). Bullying at work: bullying, burnout and well-being among assistant nurses. *Journal of Occupational Health and Safety, 14*(6), 563-568.
- Einarsen, S., & Mikkelsen, E. (Eds.). (2003). *Individual effects of exposure to bullying at work. In bullying and emotional abuse in the workplace*. New York: Taylor & Francis.
- Erickson, K. (1967). A comment on disguised observation in sociology. *Social Problems, 14*, 366-375.
- Erikson, K. (1967). A comment on disguised observation in sociology. *Social Problems, 14*(4), 366-375.
- Evans-Prichard, A. (2004, October 14 2004). EU whistleblower in 130 million pound case is fired, *Telegraph.co.uk*, p. 27.
- Fahey, K. (2002). Reflecting on practice to theorise empowerment for women: using Foucault's concepts. *Australian Journal of Midwifery, 15*(1), 5-13.
- Farrell, G. (2001). From tall poppies to squashed weeds; why don't nurses pull together more? *Journal of Advanced Nursing, 35*(1), 26-33.

- Farrell, G., Bobrowski, C., & Bobrowski, P. (2006). Scoping workplace aggression in nursing: findings from an Australian study. *Journal of Advanced Nursing*, 35(1), 26-33.
- Farrell, G., & Cubit, K. (2005). Nurses under threat: a comparison of content of 28 aggression management programs. *International Journal of Mental Health Nursing*, 14(1), 44-53.
- Faunce, T., Bolsin, S., & Chan, W. (2004). Supporting whistleblowers in academic medicine; training and respecting the courage of professional conscience. *Journal of Medical Ethics*, 30(1), 40-43.
- Ferrinho, P., Biscaia, A., Fronteria, I., Craveiro, I., Antunes, A., Conceicao, C., . . . Santos, O. (2003). Patterns of perceptions of workplace violence in the Portugese health care sector. *Human Resource Health*, 1(1), 1-11
- Fields, B. (2006, 27th November - 1st December). *School discipline coverage in Australian newspapers: impact upon public perceptions, educational decisions and policy*. Paper presented at the Australian Association for Research in Education Annual Conference. Creative dissent: Constructive solutions, Parramatta.
- Fields, L. (2010, 21st October). NSW whistleblower amendments full of holes. *Magazine for the Australian centre for Independent Journalism*, 1.
- Firth-Cozens, J. (2004). Organisational trust: the keystone to patient safety. *Quality and Safety in Health Care*, 10(1), 56-61.
- Firtko, A., & Jackson, D. (2005). Do the ends justify the means? Nursing and the dilemma of whistleblowing. *Australian Journal of Advanced Nursing*, 23(1), 51-56.

- Foley, B., Minick, M., & Kee, C. (2002). How nurses learn advocacy. *Journal of Nursing Scholarship, 34*(2), 181-186.
- Fong, L. (1998). Honesty means tough time, *Melbourne Yarra Leader June 22nd*, p. 9.
- Fontana, A., & Frey, J. (1994). Interviewing: the art of science. In N. Denzin & Y. Lincoln (Eds.), *Handbook of qualitative research* (pp. 361-376). Thousand Oaks California: Sage Publications.
- Fox, S., & Stallworth, L. (2003). Racial/ethnic bullying: exploring links between bullying and racism in the US workplace. *Journal of Vocational Behaviour, 66*(3), 438-456.
- Franklin, B. (1999). *Misleading messages: the media and social policy*. New York: Routledge.
- Gadow, S. (1990). Existential advocacy: philosophical foundations of nursing In S. Spicker & S. Gadow (Eds.), *Nursing images and ideals. Opening dialogue with the humanities* (pp. 79-101). New York: Springer Publishing.
- Garland, A. (1999). Beware the bully. *Nursing Standard, 13*(23), 65-67.
- Garrett, L., Chan, K., Brykczynski, R., Malone, E., & Benner, P. (2010). *Interpretive phenomenology in health care research*. Indianapolis: Sigma Theta Tau International.
- Gerbner, G., Gross, L., Morgan, M., & Signorielli, N. (1980). The 'mainstreaming' of America: Violence profile no. 11. *Journal of Communication, 30*(3), 10-29.
- Gerrish, K. (1997). Being a marginal native: dilemmas of the participant observer. *Nurse Researcher, 5*(1), 25-34.

- Gibson, T., & Heartfield, M. (2003). Contemporary enrolled nursing practice: opportunities and issues. *Collegian, 10*(1), 22-26.
- Gibson, T., & Heartfield, M. (2005). Australian enrolled nurses have their say. Part 2: Scope of practice. *Contemporary Nurse, 19*(1), 126-136.
- Gini, G. (2008). Associations between bullying behaviour, psychosomatic complaints, emotional and behavioural problems. *Journal of Paediatrics and Child Health, 44*(9), 492-497.
- Gleeson, M. (1998). Nurses, nursing and unlicensed workers providing nursing care. *Australian Nursing Journal, 5*(7), 20-21.
- Gopal, A., & Prasad, P. (2000). Understanding GDSS in symbolic context: shifting the focus from technology to interaction. *MIS Quarterly, 24*(3), 509-546.
- Grace, P. (2001). Professional advocacy: widening the scope of accountability. *Nursing Philosophy, 2*(2), 151-162.
- Grant, C. (2002). Whistleblowers: saints of secular culture. *Journal of Business Ethics, 39*(4), 391-399.
- Greene, J., & Caracelli, V. (Eds.). (1997). *Advances in mixed method evaluation: the challenge and benefits of integrating diverse paradigms*. San Francisco: Jossey-Bass.
- Gregor, M. (1996). Practical philosopher. In M. T. Gregor (Ed.), *The Cambridge edition of the works of Immanuel Kant* (pp. 273-309). Cambridge: New York: Cambridge University Press.
- Gregory, D., Russell, C., & Phillips, L. (1997). Beyond textual perfection: transcribers as vulnerable persons. *Qualitative Health Research, 7*(2), 294-300.

- Gretter, L. (1893). The Nightingale pledge. Retrieved from <http://www.countryjoe.com/nightingale/pledge.html>
- Griffin, M. (2004). Teaching cognitive rehearsal as a shield for lateral violence: an intervention for newly licensed nurses. *Journal of Continuing Education in Nursing, 35*(6), 257-263.
- Groeblinghoff, D., & Becker, M. (1996). A case study of mobbing and the clinical treatment of mobbing victims. *European Journal of Work and Organisational Psychology, 5*(2), 277-294.
- Grover, K. (1996). *How do the perceptions and expectations of individual, university prepared new graduate nurses compare with the reality of practising as registered nurse clinicians in the first year of practice?* Master of Health Management [hons], University of New England, Armidale.
- Gupa, E. (1990). *The paradigm dialogue*. Newbery Park California: Sage Publications.
- Haines, A., & Donald, A. (1998). Making better use of research findings. *British Medical Journal, 317*(7150), 72-75.
- Halse, C., & Honey, A. (2005). Unraveling ethics: illuminating the moral dilemmas of research ethics. *Signs, 30*(4), 2141-2162.
- Hammersley, M., & Atkinson, P. (1994). Ethnography and participant observation. In N. Denzin & L. Y (Eds.), *Handbook on qualitative research*. Thousand Oaks California: Sage Publications.
- Hansen, A., Hogh, A., Persson, R., Karlson, B., Gadre, A., & Orbeak, P. (2006). Bullying at work, health outcomes and physiological stress response. *Journal of Psychosomatic Research, 60*, 63-72.

- Harrigan, P. (1994). London perspective: health care financing in Australia. *The Lancet*, 344(8919), 347-350.
- Health Care Complaints Commission. (2003). Investigation report into Campbelltown and Camden hospitals and Macarthur Health Service (pp. 1-377). Sydney: Health Care Complaints Commission.
- Heartfield, M., & Gibson, T. (2005). Australian enrolled nurses have their say. Part 1: Teamwork and recognition. *Contemporary Nurse*, 19(1), 115-125.
- Hegney, D., & McCarthy, A. (2000). Job satisfaction and nurses in rural Australia. *Journal of Nursing Administration*, 30(7/8), 347-350.
- Hegney, D., Tuckett, A., Parker, D., & Eley, M. (2010). Workplace violence: differences in perceptions of nursing work between those exposed and those not exposed. A cross-sector analysis. *International Journal of Nursing Practice*, 16(2), 188-202.
- Heidegger, M. (1962). *Being and time* (J. Macquarie & E. Robinson, Trans.). New York: Harper Row.
- Hockley, C. (2000, 7-8 December). *Women stalking women in the workplace: a preliminary study of nurses' experiences*. Paper presented at the Stalking: Criminal Justice Responses Conference, Sydney Australia.
- Hogg, M., Terry, D., & White, K. (1995). A tale of two theories: a critical comparison of identity theory with social identity theory. *Social Psychology Quarterly*, 58(4), 255-269.

- Holden, R. (1996). Nursing knowledge the problem of the criterion. In J. Kikuchi, S. Simmons & D. Romyn (Eds.), *Truth in nursing inquiry*. Thousand Oaks California: Sage.
- Holland, C. (1999). A journey to becoming: the student nurse in transition. *Journal of Advanced Nursing*, 29(1), 229-236.
- Holly, C. (1993). The ethical quandaries of acute care nursing practice. *Journal of Professional Nursing*, 9(2), 110-115.
- Holmes, B. (2005a, 8th May 2012). ICAC report rejects allegations about SWAHS. *NSW Nurses' Association: Union news* Retrieved from <http://www.nswnurses.asn.au/news/3590.html>
- Holmes, B. (2005b). Mistakes made, but gossip damaged nurses. *NSW Nurses' Association: Union news* Retrieved from <http://www.nswnurses.asn.au/news/3590.html>
- Holmes, C. (2006). Violence, zero tolerance and the subversion of professional practice. *Contemporary Nurse*, 21(2), 212-225.
- Horley, J. (2011). On the tyranny of professional labelling. *Psychotherapy, Politics International*, 9(2), 127-133.
- Hunt, G., & Shailer, B. (1995). The whistleblowers speak. In G. Hunt (Ed.), *In whistleblowing in the health service* (pp. 3-21). London: Edward Arnold.
- Hutchinson, M., Vickers, M., Jackson, D., & Wilkes, L. (2005). "I'm gonna do what I wanna do!" Organisational change as a legitimised vehicle for bullies. *Health Care Manager Review*, 30(4), 331-338.

- Hutchinson, M., Vickers, M., Jackson, D., & Wilkes, L. (2006). Workplace bullying in nursing: towards a more critical organisational perspective. *Nursing Inquiry, 13*(2), 118-126.
- Independent Commission Against Corruption. (2005a). *ICAC Report: Report on investigation into the alleged mistreatment of nurses*. Sydney: Independent Commission Against Corruption
- Independent Commission Against Corruption. (2005b). *Report on investigation into various allegations relating to the former South Western Sydney Area Health Service*. Sydney: New South Wales State Government.
- Infante, D., Rancer, A., & Womack, D. (1997). *Building communication theory (3rd ed)*. Prospect Heights: Waveland.
- Ip, M., Gilligan, T., & Koenig, B. (1998). Ethical decision making in critical care in Hong Kong. *Journal of Critical Care Medicine, 26*(3), 447-451.
- Ishmael, A. (1999). *Harassment, bullying and violence at work: a practical guide to combating employee abuse*. Newcastle: Industrial Society.
- Jackson, D. (2008a). Editorial: Collegial trust: crucial to safe and harmonious workplaces *Journal of Clinical Nursing, 17*(12), 1541-1542.
- Jackson, D. (2008b). What becomes of the whistleblowers? *Journal of Clinical Nursing, 17*(10), 1261-1262.
- Jackson, D., Clare, J., & Mannix, J. (2002). Who would want to be a nurse? Violence in the workplace - a factor in recruitment and retention. *Journal of Nursing Management, 10*(1), 13-20.
- Jackson, P. (1999). Whistles and safety valves. *CA Magazine, 132*(3), 43-44.

- Jackson, P., Peters, K., Andrew, S., Edinburgh, M., Halcomb, E., Luck, L., . . . Wilkes, L. (2010). Trial and tribulation: a qualitative study of whistleblowing and workplace relationships in nursing. *Contemporary Nurse, 36*(1), 34-44.
- Joel, I. (1997). Moral compromise: burnout revisited. *American Journal of Nursing, 97*(10), 7-8.
- Johnson, M., & Yates-Bolton, N. (2007). Valuing of altruism and honesty in nursing students: a two-decade replication study. *Journal of Advanced Nursing, 57*(4), 366-374.
- Johnstone, B., & Macleod Clarke, J. (2003). Collecting sensitive data: the impact upon researchers. *Qualitative Health Research, 13*(3), 421-434.
- Johnstone, M. (1994). *Nursing and the injustices of the law*. Orlando Florida United States of America: Harcourt Brace Company.
- Jopson, D. (2003, December 12). Whistleblower nurses wary of inquiry, *Sydney Morning Herald*, p. 7.
- Jos, P. (1991). The nature and limits of the whistleblowers contribution to administrative responsibility. *American Review of Public Administration, 21*(2), 105-118.
- Jos, P., Tompkins, M., & Hays, S. (1989). In praise of difficult people: a portrait of the committed whistleblower. *Public Administration Review, 49*(6), 552-561.
- Jubb, P. (1999). Whistleblowing: a restrictive definition and interpretation. *Journal of Business Ethics, 21*(1), 77-94.

- Keeling, A. (2004). Blurring the boundaries between medicine and nursing: coronary care nursing, circa the 1960's. *Nursing History Review*, 12, 139-164.
- Kelly, A. (2004). One practice nurses's perspective. *Community Practice*, 77(6), 224-226.
- Kelly, B. (1993). The 'real world' of hospital nursing practice as perceived by nursing undergraduates. *Journal of Professional Nursing*, 9(1), 27-33.
- Khalil, D. (2009). Levels of violence among nurses in Cape Town public hospitals. *Nursing Forum*, 44(3), 207-217.
- Kidd, J., & Finlayson, M. (2006). Navigating uncharted water: research ethics and emotional engagement in human inquiry. *Journal of Psychiatric and Mental Health Nursing*, 13(4), 44-55.
- Kimberley, A., Myers, H., Davis, S., Keogh, P., & Twigg, D. (2004). Enrolled nurse medication administration. *Contemporary Nurse*, 17(1), 63-70.
- Kingston, M., Evans, S., Smith, B., & Berry, J. (2004). Attitudes of doctors and nurses towards incident reporting: a qualitative analysis. *Medical Journal of Australia*, 181(1), 36-39.
- Kirk, A. (2008). GP's ordering unnecessary pathology tests: Medicare watchdog AM Retrieved from www.abc.net.au/am/content/2008/s2206589.htm
- Kite, K. (1999). Participant observation, peripheral observation of a participant observation? *Nurse Researcher*, 7(1), 44-55.
- Kline, A. (2006). On complicity theory. *Science and Engineering Ethics*, 12(2), 257-264.

- Koryagin, A. (1989). The involvement of Soviet psychiatry in the persecution of dissenters. *British Journal of Psychiatry*, 154(3), 336-340.
- Lagerspetz, K., Bjorkqvist, K., & Peltonen, T. (1988). Is indirect aggression typical of females? Gender differences in aggressiveness in 11-12 year old children. *Aggressive Behaviour*, 14, 403-414.
- Lalor, J., Begley, C., & Devane, D. (2006). Exploring painful experiences: impact of emotional narratives on members of the qualitative research team. *Journal of Advanced Nursing*, 56(6), 606-616.
- Lange, A., & Cheek, J. (1997). Health policy and the nursing profession: a deafening silence. *International Journal of Nursing Practice*, 3(1), 2-9.
- Latimer, P., & Brown, A. (2007). In whose interest? The need for consistency in to whom and about whom, Australian public interest whistleblowers can make protected disclosures. *Deakin Law Review*, 12(2), 1-21.
- Lee, M., & Solomon, N. (1990). *Unreliable sources: a guide to detecting bias in news media*. New York: Lyle Stuart.
- Lee, R., & Renzetti, C. (1990). The problems of researching sensitive topics: an overview and introduction. *American Behavioural Scientist*, 33(5), 510-528.
- Leeder, S. (1998). Australia - mixed heritage and uncertain future in healthcare. *The Lancet*, 351(23), 1569-1578.
- Legislative Council, G. P. S. C. (2006). Review of Inquiry into complaints handling within NSW Health (pp. 82). Sydney: NSW Legislative Assembly.
- Leiper, J. (2005). Nurse against nurse: how to stop horizontal violence. *Nursing Forum*, 35(3), 44-45.

- Lemert, E. (1951). *Social pathology*. New York: McGraw-Hill Book Company Inc.
- Lennane, J. (1993). Whistleblowing: a health issue. *British Medical Journal*, 307(6905), 667-670.
- Lennane, J. (2000). Battered plaintiffs: injuries from hired guns and compliant courts. *Whistleblowers Australia - Suppression of dissent*
Retrieved from
www.bmartin.cc/dissent/documents/Lennane_battered.html
- Leonard, V. (Ed.). (1999). *A Heideggerian phenomenological perspective on the concept of the person*. Philadelphia: Lippincott.
- Lewis, M. (2001). Bullying in nursing. *Nursing Standard*, 14(45), 39-42.
- Lewis, M. (2006). Nurse bullying: organisational considerations in the maintenance and perpetration of health care bullying cultures. *Journal of Nursing Management*, 14(1), 25-58.
- Lewis, S. (2003). Caring as being: unique or ubiquitous. *Nursing Science Quarterly*, 16(37), 37-43.
- Leymann, H. (1990). Mobbing and psychological terror at workplaces. *Violence and Victims*, 5(2), 119-126.
- Leymann, H. (1996). The content and development of mobbing at work. *European Journal of Work and Organisational Psychology*, 5(2), 165-184.
- Leymann, H. (2006). Mobbing and bullying. *The Chronicle of Higher Education*, 52(32), 10.

- Liaschenko, L. (1993). Feminist ethics and cultural ethos; revisiting a nursing debate. *Advances in Nursing Science* 15(4), 71-81.
- Light, C. (2001). Whistleblower protection: returning the healthcare professional to the advocate role. *Kansas Nurse*, 76(6), 1-2.
- Lopez, K., & Willis, D. (2004). Descriptive versus interpretive phenomenology: their contributions to nursing knowledge. *Qualitative Health Research*, 14(5), 726-735.
- Lowe, J. (1994). Developing cultural competence. *Florida Nurse*, 42(2), 16.
- Lowe, J., & Archibald, C. (2009). Cultural diversity: the intention of nursing. *Nursing Forum*, 44(1), 11-18.
- Lowe, J., & Struthers, R. (2001). A conceptual framework of nursing in the Native American culture. *Journal of Nursing Scholarship*, 33(3), 279-283.
- Ludwig, L. (2010). *Government announces whistleblower protection scheme*. Canberra: Australian Federal Government Retrieved from www.aph.gov.au/library/pubs/bn/pol/APSCChanges.htm.
- Maas, M., & Jacox, A. (1997). *Guidelines for nurse autonomy/patient welfare*. New York: Appleton-Century-Crofts.
- Macciocchi, S., French, L., & Bush, S. (2009). Doing good: the pitfalls of beneficence. *Journal of Head Trauma Rehabilitation*, 24(1), 72-74.
- MacDonald, H. (2006). Relational ethics and advocacy in nursing: literature review. *Journal of Advanced Nursing*, 57(2), 119-126.
- Madison, D. (2005). *Introduction to critical ethnography: method, ethics and performance*. Thousand Oaks California: Sage Publications Inc.

- Madison, J., & Minichiello, V. (2000). Recognising and labelling sex based and sexual harassment in the health care workplace. *Journal of Nursing Scholarship*, 32(4), 405-410.
- Maguire, J., & Ryan, D. (2007). Aggression and violence in mental health services: categorizing the experiences of Irish nurses. *Journal of Psychiatric and Mental Health Nursing*, 14(2), 120-127.
- Mahlin, M. (2010). Individual patient advocacy, collective responsibility and activism within professional nursing associations. *Nursing Ethics*, 17(2), 247-254.
- Mallick, M. (1997). Advances in nursing: a review of the literature. *Journal of Advanced Nursing*, 25(1), 130-138.
- Manias, E. (2001). Rethinking ethnography: reconstructing nurse relationships. Methodological issues in nursing research. *Journal of Advanced Nursing*, 33(2), 234-242.
- Martin, B. (1998). Whistleblowers fan winds of change in society. *Campus Review*, 8(28), 10.
- Martin, B., Baker, A., Manwell, C., & Pugh, C. (Eds.). (1986). *Intellectual suppression*. Ryde: New South Wales: Angus and Robertson.
- Martin, B., & Rifkin, W. (2004). The dynamics of employee dissent: whistleblowers and organisational jiu-jitsu. *Public Organisational Review: A Global Journal*, 4(3), 221-228.
- Mascord, P. (1992). The career structure and life long education. In G. Gray & R. Pratt (Eds.), *Issues in Australian nursing 3* (Vol. 1). Melbourne: Churchill Livingstone Melbourne.

- Matt, S. (2012). Ethical and legal issues associated with bullying in the nursing profession. *Journal of Nursing Law, 15*(1), 9-13.
- McAlpine, H., Krisjanson, L., & Porocho, D. (1997). Development and testing of the ethical reasoning tool (ERT): an instrument to measure the ethical reasoning of nurses. *Journal of Advanced Nursing, 25*(3), 1151-1161.
- McCabe, S., & Burman, M. (2006). The tale of two APN's: addressing blurred practice boundaries in APN practice. *Perspectives in Psychiatric Care, 42*(1), 3-12.
- McCallin, A. (2001). Interdisciplinary practice - a matter of teamwork: an integrated literature review. *Journal of Clinical Nursing, 10*(4), 419-428.
- McCarthy, P. (2003). Bullying at work: a postmodern experience. In D. Zapf, H. Hoel, C. Cooper & S. Einarsen (Eds.), *Bullying and emotional abuse in the workplace: international perspectives in research and practice* (pp. 231-244). London: Taylor and Francis.
- McConnell-Henry, T., Chapman, Y., & Francis, K. (2009a). Husserl and Heidegger: exploring the dispartity. *International Journal of Nursing Practice, 15*(1), 7-15.
- McConnell-Henry, T., Chapman, Y., & Francis, K. (2009b). Unpacking Heideggerian Phenomenology. *Southern Online Journal of Nursing Research, 9*(1), 1-11.
- McCosker, H., Barnard, A., & Gerber, R. (2001). Undertaking sensitive research: Issues and strategies for meeting the safety needs of all participants. *Qualitative Social Research, 2*(1), 1-13.

- McDonald, S., & Ahern, K. (1999). Whistleblowing: effective and ineffective coping responses. *Nursing Forum, 34*(4), 5-13.
- McDonald, S., & Ahern, K. (2000). The professional consequences of whistleblowing by nurses. *Journal of Professional Nursing, 16*(6), 313-321.
- McEwan, B. (2008). Defining the scope of practice of enrolled nurses in medication administration in Australia: A review of the legislation *Collegian, 15*(3), 93-101.
- McGuire, W., & McGuire, C. (Eds.). (1991). *The content, structure and operation of thought systems*. Hillsdale New Jersey: Erlbaum.
- McKenna, G., Smith, N., & Poole, S. (2003). Horizontal violence: experiences of registered nurses in their first year of practice. *Journal of Advanced Nursing, 42*(1), 90-96.
- McMillian, J. (1989, 13th November). *Principled organisational dissent: whistleblowing in response to corruption*. Paper presented at the Fourth International Anti-Corruption Conference, Canberra.
- McMillian, J. (1995). Losing control. *Nursing Times, 91*(15), 40.
- Media Awareness Network. (2005). Detecting bias in the news. *Newskit: A consumers guide to news media* Retrieved from http://www.media-awareness.ca/english/resources/educational/lessons/secondary/broadcast_news/upload/bias_news_lesson_kit.pdf
- Meithe, T., & Rothschild, J. (1994). Whistleblowing and the control of organisational conduct. *Sociological Inquiry, 64*(3), 322-347.
- Meleis, A. (1996). Culturally competent scholarship: substance and rigor. *Advances in Nursing Science, 19*(2), 1-16.

- Meltzer, B., Petras, J., & Reynolds, L. (1975). *Symbolic interactionism, genesis, varieties and criticism*. London: Routledge.
- Merton, R. (1995). The Thomas Theorem and the Matthew Effect. *Social Forces*, 74(2), 379-424.
- Mesmer-Magnus, J., & Viswesvaran, C. (2005). Whistleblowing in organizations; an examination of correlates of whistleblowing intentions, actions and retaliation. *Journal of Business Ethics*, 62(3), 277-297.
- Metherell, M. (2006, 12th January 2006). Watchdog sees signs of overservicing, *Sydney Morning Herald*. Retrieved from <http://www.smh.com.au/news/national/watchdog-sees-signs-of-overservicing/2006/01/11/1136956243014.html>
- Miceli, M., & Near, J. (1984). The relationships among beliefs, organisational position and whistleblowing status: a discriminate analysis. *Journal of Academic Management*, 27(4), 687-705.
- Miceli, M., & Near, J. (1992). *Blowing the whistle: The organisational and legal implications for companies and employees*. New York: Lexington.
- Miceli, M., & Near, J. (1994). Relationships among value congruence, perceived victimisation and retaliation against whistleblowers: the case of internal auditors. *Journal of Academic Management*, 20(4), 773-794.
- Miceli, M., & Near, J. (2002). What makes whistleblowers effective? Three field studies. *Human Relations*, 55(4), 445-479.
- Millette, B. (1993). Client advocacy and the moral orientation of nurses. *Western Journal of Nursing Research*, 15(5), 607-618.

- Milliken, F., Morrison, W., & Hewlin, P. (2003). An exploratory study of employee silence: issues that employees don't communicate upward and why. *Journal of Management Studies, 40*(6), 1453-1476.
- Milson-Hawke, S., & Higgins, I. (2003). The scope of enrolled nurse practice: A review of the literature. *Contemporary Nurse, 14*(2), 129-137.
- Milson-Hawke, S., & Higgins, I. (2004). The scope of enrolled nurse practice: a grounded theory study. *Contemporary Nurse, 17*(1-2), 44-62.
- Minichiello, V., Aroni, R., Timewell, D., & Alexander, L. (1996). *In-depth interviewing: principles, techniques, analysis*. Australia: Addison Wesley Longman Australia.
- Monin, B., Sawyer, P., & Marquez, M. (2008). The rejection of moral rebels: resenting those who do the right thing. *Journal of Personality and Social Psychology, 95*(1), 76-93.
- Moore, M. (2000). Ethical issues for nurses providing perinatal care in community settings. *Journal of Perinatal and Neonatal Nursing, 14*(2), 25-35.
- Moss, I. (2007). *Report on the independent audit into the state of free speech in Australia*. Sydney: Australia's Right to Know Committee Retrieved from <http://www.fxj.com.au/shareholders/AustraliasRighttoKnow-MossReport-ExecutiveSummary.pdf>.
- Musselman, L., MacRae, H., Reznick, R., & Lingard, L. (2005). You learn better under the gun: intimidation and harassment in surgical education. *Medical Education, 39*(9), 926-934.

- Nadzam, D. (2009). The Joint Commission Update: Nurses' role in communication and patient safety. *Journal of Nursing Care Quality*, 24(3), 184-188.
- Namie, G., & Namie, R. (1999, 11-13 March). *Work, stress and health '99: Private occasions of work in a global economy*. Paper presented at the Fourth interdisciplinary conference on occupational health and safety, American Psychological Association/National Institute for Occupational Safety and Health: Baltimore.
- Near, J., & Miceli, M. (1986). Retaliation against whistleblowers: predictors and effects. *Journal of Applied Psychology*, 71(1), 137-145.
- Near, J., & Miceli, M. (1995). Effective whistleblowing. *Academy of Management Review*, 20(3), 679-708.
- Nelson, C., Treichler, P., & Grossberg, L. (Eds.). (1992). *Cultural studies: an introduction*. New York: Routledge.
- New South Wales Department of Health. (2005a). *Clinician's toolkit for improving patient care*. (GL2005_062). Sydney: New South Wales Health Department Retrieved from http://www.health.nsw.gov.au/policies/gl/2005/GL2005_062.html.
- New South Wales Department of Health. (2005b). *NSW Health Code of Conduct*. Sydney: NSW Health Retrieved from http://www.health.nsw.gov.au/policies/pd/2005/pdf/PD2005_626.pdf.
- New South Wales Department of Health. (2005c). *Patient safety and clinical quality program. First report on incident management in the NSW public health system 2003 -2004*. PD 205_608. Sydney: New South Wales Health Department Retrieved from http://www.health.nsw.gov.au/policies/pd/2005/PD2005_609.html.

- New South Wales Government. (1977). *The Anti-Discrimination Act. (48)*. Sydney: The New South Wales Government.
- New South Wales Government. (2010). *Protected Disclosures Amendment. (Public Interest Disclosures) Act*. Sydney: New South Wales Government.
- New South Wales Government. (2011). *New South Wales Occupational Health and Safety Act 2000 No. 40*. Sydney: New South Wales Government Printer Retrieved from www.legislation.nsw.gov.au/maintop/view/.../act+40+2000+cd+0+N.
- New South Wales Nurses Association. (2007, 27-29 April). *Guidelines on whistleblowing and nursing*. Paper presented at the New South Wales Nurses Association Annual Conference, Sydney.
- New South Wales Nurses Association. (2009). Home - About the New South Wales Nurses Association. Retrieved from www.nswnurses.asn.au/
- New South Wales Ombudsman. (2004). *The adequacy of the Protected Disclosure Act [NSW] to achieve its objectives*. Sydney: NSW Ombudsman Retrieved from catalogue.nla.gov.au/Record/3123683.
- Nightingale, F. (1860). Notes on nursing: what it is, what it is not. Retrieved from <http://digital.library.upenn.edu/women/nightingale/nursing/nursing.html>
- Nurses Board of South Australia. (2003). *Summary of issues paper. Inquiry into the role and function of unregulated care workers in South Australia*. Adelaide: Nurses Board of South Australia Retrieved from www.nnnet.gov.au/downloads/n3et_sop_commentary_paper_final.pdf.

- O'Sullivan, P. (2005, 23rd August). *Termination of employment in the public service: learnings from a case study and 10 practical tips on disciplining public servants*. Paper presented at the The Legal Seminar, Brisbane.
- Oats, B., Murray, J., & Hindle, D. (1998). The second national hospital costing study: background, results and implications. *The Australian Health Review, 21*(3), 241-254.
- Okasha, A. (2000). Ethics of psychiatry practice: consent, compulsion and confidentiality. *Current Opinion in Psychiatry, 13*(6), 423-424.
- Oppenheim, A., & Sprung, C. (1998). Cross cultural ethical decision making in critical care. *Journal of Critical Care Medicine, 26*(3), 423-424.
- Orentlicher, D. (1992). The illusion of patient choice in end of life decisions. *JAMA, 267*(15), 2101-2104.
- Oxford English Dictionary. (1989). *Oxford English Dictionary 2nd edition*. London: Clarendon Press.
- Ozturk, H., Sokmen, Ylmaz, F., & Cilingir, D. (2008). Measuring mobbing experiences of academic nurses: development of a mobbing scale. *Journal of the American Academy of Nurse Practitioners, 20*(9), 435-442.
- Pain, C. (2006). Lessons from Campbelltown and Camden hospitals. *ANZ Journal of Surgery, 76*(1), 43.
- Paley, J. (2002a). Caring as a slave morality: Nietzschean themes in nursing ethics. *Journal of Advanced Nursing, 40*(1), 25-35.
- Paley, J. (2002b). Virtues of autonomy; the Kantian ethics of care. *Nursing Philosophy, 3*(2), 133-143.

- Parkes, R. (1994). Cost, quality, casemix and frustrated nurses. *Australian Nursing Journal*, 1(10), 30-31.
- Parmerlee, M., Near, J., & Jenson, T. (1982). Correlates of whistleblowers' perceptions of organisational reprisals. *Administrative Science Quarterly*, 27(1), 17-34.
- Paterson, B., Leadbetter, D., & Miller, G. (2005). Beyond zero tolerance: a varied approach to workplace violence. *British Journal of Nursing*, 14(15), 810-815.
- Paterson, B., McComish, A., & Aitken, I. (1997). Abuse and bullying. *Nursing Management*, 3(10), 8-9.
- Pellegrini, A., & Long, J. (2002). A longitudinal study of bullying, dominance and victimisation during the transition from primary school to secondary school. *British Journal of Developmental Psychology*, 20(2), 259-280.
- Perry, J. (1993). *Whistleblowing, organisational performance and organisational control*. New York: M. E. Sharpe Inc.
- Pollard, R. (2004, 25th June). Old girl's network holds sway, Health Report, *Sydney Morning Herald*. Retrieved from http://www.wbde.org/documents/2004_Jun_25_Camden%20Nurses_Old%20girls.php
- Quine, L. (2001). Workplace bullying in nurses. *Journal of Health Psychology*, 6(1), 73-84.
- Ramos, M. (2006). Eliminate destructive behaviours through example and evidence. *Nurse Management*, 37(9), 34-41.

- Raskauskas, J., & Stoltz, A. (2004). Identifying and intervening in relational aggression. *Journal of Scholar Nurses, 20*(4), 209-215.
- Rawnsley, M. (1972). Nursings' theoretical evolution. *Nursing Outlook, 20*(July), 449-453.
- Rhodes, L., & Strain, J. (2004). Whistleblowing in academic medicine. *Journal of Medical Ethics, 30*(1), 35-39.
- Roberts, K., & O'Reilly, C. (1974). Failures in upward communication in organisations: three possible culprits. *Academy of Management Journal, 17*(2), 205-215.
- Roberts, M. (1963). *American nursing, history and interpretation*. New York United States of America: McMillian.
- Robertson-Malt, S. (1999). Listening to them and reading me: a Hermeneutic approach to understanding the experience of illness. *Journal of Advanced Nursing, 29*(2), 290-297.
- Robertson, D. (1996). Ethical theory, ethnography and differences between doctors and nurses in approaches to patient care. *Journal of Medical Ethics, 22*(5), 292-299.
- Robertson, R. (2005). Rumours: constructive or corrosive. *Journal of Medical Ethics, 31*(9), 540-541.
- Rodney, P., Varcoe, C., Hartrick, K., McPherson, G., Mahoney, K., Brown, H., . . . Starzomski, R. (2002). Navigating towards a moral horizon: a multisite qualitative study of ethical practice in nursing. *Canadian Journal of Nursing Research, 34*(3), 75-102.

- Rosen, S., Katz, J., & Morahan, P. (2007). "Avoiding 'mobbing' in the workplace - and surviving if you are mobbed". *Academic Physician and Scientist*, 9(September), 4-5.
- Rosen, S., & Tesser, A. (1970). On reluctance to communicate undersireable information. The MUM effect. *Sociometry*, 33(3), 253-263.
- Rosenblatt, P. (Ed.). (2001). *Qualitative research as a spiritual experience*. New York: CRC Press.
- Rothschild, J., & Miethe, T. (1999). Whistleblower disclosures and management retaliation: the battle to control information about organisational corruption. *Journal of Work and Occupations*, 26(1), 107-128.
- Rowe, M., & Sherlock, H. (2005). Stress and verbal abuse in nursing: do burned out nurses eat their young? *Journal of Nursing Management*, 13(3), 242-248.
- Rowell, P. (2005). Being a 'target' at work: or William Tell and how the apple felt. *Journal of Nursing Administration*, 35(9), 377-379.
- Rowling, L. (1999). Being in, being out, being with: affect and the role of the qualitative researcher in loss and grief research. *Mortality*, 4(2), 167-182.
- Rys, G., & Bear, G. (1997). Relational aggression and peer relations: gender and developmental issues. *Merrill-Palmer Quarterly*, 49(1), 87-106.
- Salin, D. (2003). Ways of explaining workplace bullying: a review of enabling, motivating and precipitating structures and processes in the work environment. *Human Relations*, 56(10), 1213-1232.

- Saltzman, J., & Kowalczyk, L. (2007, September 29). Drug firm, subsidiary settle suites for \$515 million: pricing schemes and fraud alleged, *The Boston Globe*. Retrieved from www.boston.com/yourlife/health/blog/2007/10/
- Sandelowski, M. (1991). Telling stories: narrative approaches in qualitative research. *Journal of Nursing Scholarship, 23*(3), 161-166.
- Sandelowski, M., & Barroso, J. (2002). Finding the findings in qualitative studies. *Journal of Nursing Scholarship, 34*(3), 213-219.
- Sarvimaki, A. (1995). Aspects of moral knowledge in nursing *Scholarly Inquiry for Nursing Practice, 9*(4), 343-351.
- Sawyer, K., Johnson, J., & Holub, M. (2006). The necessary illegitimacy of the whistleblower. *Business and Professional Ethics Journal, 29*(1), 85-107.
- Selanders, L., & Crane, P. (2012). The voice of Florence Nightingale on advocacy. *Online Journal of Issues in Nursing, 17*(1). Retrieved from <http://www.nursingworld.org/MainMenuCategories/ANAMarketplace/ANAPeriodicals/OJIN/TableofContents/Vol-17-2012/No1-Jan-2012/Florence-Nightingale-on-Advocacy.html>
- Seligman, D. (1999). Blowing whistles, blowing smoke. *Forbes, 164*(5), 158-162.
- Severin, W., & Tankard, J. (1997). *Communication theories*. New York: Hastings House.
- Shahinpoor, N., & Matt, B. (2007). The power of one: dissent and organisational life. *Journal of Business Ethics, 74*(1), 37-48.

- Shallcross, L. (2003). *The pecking order: workplace mobbing in the public sector*. Master of Public Sector Management (Unpublished, Griffith University, Brisbane).
- Shallcross, L., Ramsay, S., & Barker, M. (2008, 14 - 15 October). *Workplace mobbing: expulsion, exclusion and transformation*. Paper presented at the Managing in the Pacific century, Auckland.
- Shallcross, L., Ramsay, S., & Barker, M. (2010). A proactive response to the mobbing problem: a guide for HR managers. *New Zealand Journal of Human Resource Management*, 10(1), 27-37.
- Shallcross, L., Sheehan, M., & Ramsay, S. (2008). Workplace mobbing: experiences in the public sector. *International Journal of Organisational Behaviour*, 13(2), 56-70.
- Sharp, A. (2010). A poor state of health: NSW hospitals the worst in the country. *The Sydney Morning Herald*, (29th January). Retrieved from <http://www.smh.com.au/national/a-poor-state-of-health-nsw-hospitals-the-worst-in-the-country-20100128-n1ry.html>
- Shaw, I. (2003). Qualitative research and outcomes in health, social work and education. *Qualitative Research*, 3(1), 55-77.
- Sheehan, M. (2004, 14th and 15th October). *Workplace mobbing: a proactive response*. Paper presented at the Workplace mobbing conference, Brisbane.
- Siegal, B. (1995). The compliance and adherence process in the transplant patient: professional responsibility. *Dialysis and Transplantation*, 24(4), 158-162.

- Simons, S. (2006). *Workplace bullying experienced by nurses newly licensed in Massachusetts and the relationship to intention to leave the organisation*. Ph.D, University of Massachusetts, Boston.
- Sloan, A. (1997). Whistleblowing and patient advocacy: do the right thing ... but do it right. *Virginia Nurse Today*, 15(3), 14-15.
- Smith, A. (2004). Patient advocacy: roles for nurses and leaders. *Nursing Economics*, 22(2), 1.
- Smith, K., & Godfrey, N. (2002). Being a good nurse and doing the right thing: a quantitative study. *Nursing Ethics*, 9(3), 301-302.
- Spicer, J. (2008). Distributive justice. *Practice Nurse*, 36(9), 45-48.
- Spradley, J. (1979). *The ethnographic interview*. New York: Holt, Rinehart and Winston.
- Sprung, C., Eidelman, L., & Steinberg, A. (1997). Is the patient's right to die evolving into a duty to die? Medical decision making and ethical evaluations in health care. *Journal of Evaluation in Critical Practice*, 3(1), 69-75.
- Stevens, L., & Fiske, S. (1995). Motivation and cognition in social life: a social survival perspective. *Social Cognition*, 13(3), 189-214.
- Stringer, K. (2006, 12-14 September). *Report on the 2005 survey of enrolled nurses working in the Western Australian public health system*. Paper presented at the Royal College of Nursing, Australia Annual Conference, Cairns, Australia.
- Stubblefield, C., & Murray, R. (2002). A phenomenologic framework for psychiatric nursing research. *Archives of Psychiatric Nursing*, 16(4), 149-155.

- Suchman, M. (1995). Managing legitimacy: strategic and institutional approaches. *Academy of Management Review*, 20(3), 571-610.
- Surbone, A. (1994). Informed consent and truth in medicine. *European Journal of Cancer*, 30A(14), 2189.
- Surbone, A. (1997). *Information, truth and communication: for an interpretation of truth telling practices throughout the world* (Vol. 809). New York: The New York Academy of Sciences.
- TAFE NSW. (2009). Nursing (Enrolled/Division 2 Nursing) - Course Information. Retrieved from <https://www.tafensw.edu.au/howex/courseOfferingDetail.do?>
- Tarlier, D. (2004). Beyond caring: the moral and ethical bases of responsive nurse-patient relationships. *Nursing Philosophy*, 5(3), 230-241.
- Tarlier, D., Johnson, J., & Whyte, N. (2003). Voices from the wilderness: an interpretive study describing the role and practice of outpost nurses. *Canadian Journal of Public Health*, 94(3), 180-184.
- Taylor, S., White, B., & Muncer, S. (1999). Nurses' cognitive structural models of work-based stress. *Journal of Advanced Nursing*, 29(4), 974-983.
- The Nobel Foundation. (2000). Kim Dae-jung: Nobel peace prize 2000. *Les Prix Nobel*. Retrieved from www.regent.edu/acad/global/publications/ijls/.../Choi_Vol2Iss3.pdf
- Thomas, W., & Thomas, D. (1928). *The child in America*. New York: Knopf.
- Tibbo, P., De Gara, C., Blake, T., Steinberg, C., & Stonehocker, B. (2002). Perceptions of intimidation in the psychiatric environment in Edmonton, Alberta. *Journal of Psychiatry*, 47(6), 562-567.

- Toffoli, L., & Ridge, T. (2006). Organisational predicaments: ethical conditions for nursing research. *Journal of Advanced Nursing*, 56(6), 600-606.
- Toynbee, P. (1999, 13th January). The quiet achiever, *The Guardian*. Retrieved from blogs.guardian.co.uk/cultureculture/archives/cat-145/
- Tuckett, A. (2005). Applying thematic analysis to practice: a researcher's experience. *Contemporary Nurse*, 19(1), 75-87.
- Vaartio, H., Leino-Kilpi, H., Salanterä, S., & Tarja, R. (2006). Nursing advocacy: how is it defined by patients and nurses, what does it involve and how is it experienced? *Scandinavian Journal of Caring Sciences*, 20(3), 530-533.
- Van Manen, M. (1990). *Researching lived experience: human science for and action sensitive pedagogy*. Albany: State University of New York Press.
- Vaughin, R., Devine, T., & Henderson, K. (2003). The whistleblower statute prepared for the organisation of American States and the global legal revolution protecting whistleblowers. *The George Washington International Law Review*, 35(4), 857-902.
- Vincent, J. (1992). Limiting therapy in the hopelessly ill patient: European attitudes. In J. Hall, G. Schmidt & L. Wood (Eds.), *Principles of critical care*. New York United States of America: McGraw Hill Incorporated.
- Vincent, J., Parquier, J., & Preiser, J. (1989). Terminal events in the intensive care unit: review of 258 fatal cases in one year. *Journal of Critical Care Medicine*, 17(6), 530-533.
- Wakefield, J. (2007). *Patient safety: from learning to action. First Queensland Health report on clinical incidents and sentinel events*.

Brisbane: Queensland Health Retrieved from
www.health.qld.gov.au/psq/html/john_wakefield.asp.

- Walker, L. (1900). How to prepare nurses for the duties of the alumnae. In N. Birnbach & S. Lewenson (Eds.), *First words. Selected addresses from the National League for Nursing, 1894-1933* (pp. 203-207). New York: NLN Press.
- Warne, S., & Walters, H. (2006). Pressure against rising violence. *Australian Nursing Journal, 14*(3), 21-24.
- Warnock, M. (1998). *An intelligent persons guide to ethics*. London: Duckworth.
- Weaver Moore, L., & Miller, M. (1999). Initiating research with doubly vulnerable populations. *Journal of Advanced Nursing, 30*(5), 1034-1040.
- Weber, J. (1996). Influences upon managerial moral decision making: nature of the harm and magnitude of consequences. *Human Relations, 49*(1), 1-20.
- Wellford, C. (1975). Labelling theory and criminology: an assessment. *Social Problems, 22*(3), 332-345.
- Westhues, K. (2004). *Administrative mobbing at the university of Toronto*. Lewiston New York: The Edwin Mellen Press.
- Whitton, E. (2000). In function of the press. *Australian Press Council News, 12*(3), 3. Retrieved from www.presscouncil.org.au/
- Wilde, V. (1992). Controversial hypotheses on the relationship between researcher and informant in qualitative research. *Journal of Advanced Nursing, 17*(2), 234-242.

- Williams, F., Chaboyer, W., & Patterson, L. (2000). Australia's nursing workforce in perspective. *Journal of Nursing Administration, 30*(6), 304-308.
- Wilmot, S. (2000). Nurses and whistleblowing: the ethical issues *Journal of Advanced Nursing, 32*(5), 1051-1057.
- Wilson, J., & Wilson, S. (2001). *Mass media, mass culture: an introduction (5th ed)*. Boston: McGraw-Hill.
- Wilson, L. (1991). US businesses suffer from workplace trauma. *Personnel Journal, 70*(7), 47-50.
- Wimmer, R., & Dominick, J. (1991). *Mass media research: an introduction (3rd ed)*. Belmont: California: Wadsworth.
- Wu, A. (2000). Medical error: the second victim: the doctor who makes the mistake needs help too. *British Journal of Nursing, 320*(7237), 726-727.
- Yeargain, J., & Kessler, L. (2010). Organisational hostility towards whistleblowers. *Journal of Legal, Ethical and Regulatory Issues, 13*(1), 89-92.
- Yildirim, A., & Yildirim, D. (2007). Mobbing in the workplace by peers and managers: mobbing experienced by nurses working in health care facilities in Turkey and its effect on nurses. *Journal of Clinical Nursing, 16*(8), 1444-1453.
- Yildirim, D. (2009). Bullying among nurses and its effects. *International Nursing Review, 56*(4), 504-511.
- Ziegler, S. (2007). Pain, patients and prosecution: who is deceiving whom? *American Academy of Pain Medicine, 8*(5), 445-446.

Zipparo, L. (1999). Encouraging public sector employees to report workplace corruption. *Australian Journal of Public Administration*, 58(2), 83-93.

Zoucha, R., & Husted, G. (2000). The ethical dimensions of delivering culturally congruent nursing health care. *Issues in Mental Health Nursing*, 21(3), 325-340.

Appendix 1: Information sheet for participants



School of Health
Faculty of The Professions
Armidale NSW 2351
Phone 61 2 6773 No.
Fax 61 2 6773 3666
Email: groverk@une.edu.au

Information sheet about the research proposal as described by Kathrine Grover

Name of the study:

An Australian whistleblowing experience in healthcare: A study of six women from the New South Wales public health system who were labelled by the media as whistleblower nurses.

Name of the researcher:

Kathrine Grover

Supervisors of the study:

- Professor Victor Minichiello
- Professor Jeanne Madison

Aim of the study:

To identify the cause and effect whistleblowing may have upon the professional, personal and social lives of nurses who publicly advocate for their patients.

Objective of the study:

To study the phenomena of whistleblowing in nursing and to strategise how to protect nurses of the future who publicly advocate for their patients.

Conduct of the study:

- It is anticipated this research will be conducted over the course of 3 interviews.
- Each interview may last up to 2 hours.

- The time of the meeting will be at the discretion of the participant.
- The venue will be at the discretion of the participant.
- The interviews will be audio-taped by the researcher who will then convert the data to text.
- Hardcopies of the transcribed data will be returned to each participant to ensure the researcher has accurately interpreted the information as it was intended. Once satisfied the data is an accurate representation of the interview, the participant is requested to sign the bottom of each page and return to the researcher in the stamped, addressed envelope provided.
- If pre-arranged meeting times are no longer suitable, please contact Kathrine Grover as per the contact details below to reschedule to a more convenient time.

Risks:

- Exposure to sensitive information or the retelling of stories may resurrect memories which may be disturbing or upsetting. Should you experience protracted feelings of sadness or upset, you are advised to seek professional counselling or support through your local health service.
- It is possible the manifestation of feelings may occur after the interview is complete and the researcher has left the chosen venue. If you do experience this type of reaction, please ensure you inform the researcher.

Contacts for Kathrine Grover

Phone: (02) 47740215

Mobile: 0418257769

Email: nimerlin@bigpond.com

Appendix 2: Participant consent form



School of Health
Faculty of The Professions
Armidale NSW 2351
Phone 61 2 6773 No.
Fax 61 2 6773 3666
Email: groverk@une.edu.au

Participant Consent Form

Name of the study:

An Australian whistleblowing experience in healthcare: A study of six women from the New South Wales public health system who were labelled by the media as whistleblower nurses.

Name of the researcher:

Kathrine Grover

I

Name (please print)

Of

.....

Address (please print)

Give my consent to voluntarily participate in the research study as named above.

In giving my consent, I acknowledge that:

1. I may withdraw at any time
2. I understand the study will be conducted in a manner conforming to ethical and scientific principles as defined by the National Health and Medical Research Council of Australia.

3. The study will be carried out as described in the attached information sheet. I acknowledge I have read and understood the information provided about this study, and that this information was provided to me before I signed the consent form.
4. The general purpose, method and demands with possible risks which may occur as a result of participation in this study have been explained to me by Kathrine Grover.
5. I understand the information provided by me will remain strictly confidential to the extent permitted by the relevant privacy laws.
6. I have been given the opportunity to have a friend or relative present with me when the study was explained.
7. I have been advised the University of New England Research Ethics Committee has approved this study
8. This project has been approved by the Human Research Ethics Committee of the University of New England.

Ethics approval number: HE06/164
Valid to: 1/6/2012

Should you have any concerns or complaints regarding the manner in which this research is conducted, please contact the Research Ethics Officer at:

Research Services
University of New England
Armidale, NSW 2351

Telephone: 67733449
Fax: 67733543
Email: Ethics@pobox.une.edu.au

Signature: Date:

Name:

Witness: Date:

Appendix 3: Time Line of Events for Each of the Nurses

Name	Report of issues within hospital	Time employed after report lodged	After internal (organisation) reporting, did retaliation occur?	Outcome for nurse after report of concerns	Did retaliation occur in future role as a result of labelling as a whistleblower
Monique	2003	2003 A few months.	2005 <u>Yes.</u> Accused of being a drug dependent nurse. Reported to the Nurses Registration Board	2004 Resigned	2008 Reported an adverse outcome as an Agency nurse. All shifts cancelled.
Meadhbh	2000-2003	2002-2003 2-3 months.	2004 <u>Yes.</u> Complaint lodged by Anaesthetic Registrar. Segregated from other staff. Suppression Order by hospital management.	2004 Escorted off the premises. Dismissed from position.	2008 No.
Yanaha	2002	2002-2003 2-3 months.	2004 <u>Yes.</u> Segregated from other staff. Suppression Order by hospital management.	2004 Escorted off the premises. Dismissed from position.	2008 Yes. Defamed by a doctor. Assaulted and pushed across a corridor by the same doctor.
Violet	2002	2002-2003 A year.	2004 <u>Yes</u> Accused of false reporting. Segregated from other staff. Suppression Order.	2004 Resigned.	2008 No longer works in nursing.

Name	Report of issues within hospital	Time employed after report lodged	After internal (organisation) reporting, did retaliation occur?	Outcome for nurse after report of concerns	Did retaliation occur in future role as a result of labelling as a whistleblower
Simone	2002-2003	2002-2003 Several months.	2004 <u>Yes.</u> Professional criticism and marginalisation by managers and co-workers. Threat from Minister for Health that she could lose her job.	2004 Went on stress leave and never returned to her position.	2008 Criticised by women socially. Accused of getting a payout for speaking out. Staff remain cautious in her presence
Kathrine	2002	2003 6 months	2004 <u>Yes.</u> Professionally marginalised. Attempts to discredit. Refused support by management.	2004 Went on stress leave then resigned.	2008 Life time ban on career advancement by NSW Health. Bullying and harassment by other managers.

Appendix 4: Glossary of Terms

Abbreviation	Description
ABS	Australian Bureau of Statistics
ACHS	Australian Council on Healthcare Standards
ACT	Australian Capital Territory
AIHW	Australian Institute of Health and Welfare
Caesar	Caesarean Section
Cert IV	Certificate Four
CNS	Clinical Nurse Specialist
CTH	Commonwealth
DEET	Department of Education and Training
DRG	Disease Related Group
EQUIP	Evaluation and Quality Improvement Program
ERT	Ethical decision making tool
GTN	Glycerol Tri Nitrate
HCCC	Health Care Complaints Commission
HREC	Higher Research and Ethics Committee
ICAC	Independent Commission against Corruption
ICU	Intensive Care Unit
ILO	International Labour Organisation
IM	Intramuscular
LMA's	Laryngeal Masks

MET	Medical Emergency Team
NCRM	National Centre for Research Methods
NSW	New South Wales
QALY	Quality Adjusted Life Year
QLD	Queensland
QUALITI	Qualitative Research in the Social Sciences. Innovation, Integration and Impact
RN	Registered Nurse
SA	South Australia
TAFE	Technical and Further Education
TAS	Tasmania
VIC	Victoria

Interchangeable terms

1. Nurses Registration Board *and* Nurses and Midwives Board.
2. NSW Health, New South Wales Department of Health *and* Ministry of Health.
3. Whistleblower, informant *and* advocate.