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Clinical governance breakdown: Australian cases of wilful blindness and whistleblowing

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Abstract

Background: After their attempts to have patient safety concerns addressed internally were ignored by wilfully blind managers, nurses from Bundaberg Base Hospital and Macarthur Health Service felt compelled to 'blow the whistle'. Wilful blindness is the human desire to prefer ignorance to knowledge; the responsibility to be informed is shirked.

Objective: To provide an account of instances of wilful blindness identified in two high-profile cases of nurse whistleblowing in Australia.

Research design: Critical case study methodology using Fay's Critical Social Theory to examine, analyse and interpret existing data generated by the Commissions of Inquiry held into Bundaberg Base Hospital and Macarthur Health Service patient safety breaches. All data was publicly available and assessed according to the requirements of unobtrusive research methods and secondary data analysis.

Ethical considerations: Data collection for the case studies relied entirely on publicly available documentary sources recounting and detailing past events.

Findings: Data from both cases reveal managers demonstrating wilful blindness towards patient safety concerns. Concerns were unaddressed; nurses, instead, experienced retaliatory responses leading to a 'social crisis' in the organisation and to whistleblowing.

Conclusion: Managers tasked with clinical governance must be aware of mechanisms with the potential to blind them. The human tendency to favour positive news and avoid conflict is powerful. Understanding wilful blindness can assist managers' awareness of the competing emotions occurring in response to ethical challenges, such as whistleblowing.

Keywords

Nurses, nursing, reporting, whistleblowing, wilful blindness

Introduction

A 'nurse whistleblower' is a nurse who 'identifies an incompetent, unethical or illegal situation in the workplace [then] reports it to someone who may have the power to stop the wrong'.[1] Reports are usually

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made to an authority outside a healthcare organisation in the expectation that the perceived wrongdoing will be remedied by that authority. Nurse whistleblowing is a rare event, usually taken as a last resort. When it does occur, the effects reverberate through the health service, affecting the personal and professional well-being of the whistle-blower and others within the organisation.[2–4]

Healthcare in acute hospitals is delivered by regulated health professionals working in imperfect systems, constrained by heavy workloads, inadequate resources and increasing public expectations.[5,6] These conditions increase the risk of error for clinicians and may lead to failure to meet prescribed standards of practice. When things go wrong in healthcare organisations, healthcare professionals are expected to capture the event in an incident reporting system, or report verbally to line managers.[7] Reporting is the first essential step in the identification of systemic gaps and weaknesses. Capacity to improve patient safety relies on a feedback loop that provides constructive, responsive communication back to those reporting.[8] When there is repeated inaction, or when a culture of blame and retaliation exists, the person reporting is faced with the difficult decision to either remain silent or escalate the concern, first to a higher authority within the organisation, and, if unresolved, outside the organisation.

The infrequent nature of nurse whistleblowing means little is known about the contextual processes that influence a nurse to engage in whistleblowing. However, within the last 15 years, two high-profile Australian cases of nurse whistleblowing received widespread media attention: Bundaberg Base Hospital (BBH) in Queensland and Macarthur Health Service (MHS) in New South Wales. Both incidents resulted in the establishment of commissions of inquiry. The proceedings from these cases provide a unique opportunity to examine questions related to factors influencing whistleblowing. The wealth of information presented into evidence at the commissions of inquiry facilitated in-depth data mining of the contextual factors linking flaws in internal responses – including wilful blindness – to subsequent/consequent whistleblowing.

Background

Discourse related to nurse whistleblowing first appears in the literature in the 1980s,[9,10] with research into nursing and whistleblowing beginning with King.[11] Since then, a range of studies examining the complexities associated with nurses who report patient safety concerns internally and, when no action is taken, blow the whistle, have appeared.[12,13–18] The research indicates that nurses hold strong views that internal reporting will not be listened to, leading to the perception that little or nothing would be done about the issue of concern.[12,13–17,19]

A number of human factors influence the manner in which organisations address patient safety concerns. Health service managers faced with reports of failure – particularly issues that raise concerns about patient safety – naturally demonstrate a human response. In the cases examined here that response was to ‘turn a blind eye’. Inaction following reports of failure has been described as ‘wilful blindness’ or ‘wilful ignorance’. The phenomenon of wilful blindness has been defined by Heffernan[20] as ‘shirking’ the ‘opportunity for knowledge, and a responsibility to be informed’, it is ‘the human desire at times to prefer ignorance to knowledge, and to deal with conflict and change by imagining it out of existence’.[20] Wilful blindness is a process by which the brain filters and edits what it takes in, only admitting ‘information that makes us feel great about ourselves, while conveniently filtering whatever unsettles our fragile egos and most vital beliefs’.[20] While the wilful blindness process and the human factors involved have not been directly examined by research, there is evidence in the literature of healthcare managers who apparently distance themselves from those staff raising concerns about patient safety.[18,19]

In total, 2000 managers and clinicians from the UK National Health Service (NHS) were surveyed regarding quality of leadership, transparency and whistleblowing. Clear disparities emerged between medical staff, nursing staff and those identified as executive directors in the perception of the ‘culture of

voice'.[21] The findings indicate that while '94% of executive directors' believed staff would raise concerns, 'only 57% of nurses' would do so. Asked whether concerns were handled appropriately, 90% of executive directors believed they were, whereas 'only 26% of nurses agreed'.[21] In another national survey of 624,000 NHS staff, 93% implied that they knew how to report concerns, yet only 57% were confident their concerns would be addressed.[22] Dixon-Woods et al.'s [23] study of UK NHS management and executive action to reported patient safety concerns noted that while investment had been made into data collection and monitoring systems, the extent to which this was 'translated into actionable knowledge, and then into effective organisational responses' was reliant upon managers and/or executive reactions/choices. Clearly, translating reports into action depends on the individual human response of managers and executives. This internal inaction is wilful blindness and can drive nurses and other healthcare professionals to resort to whistleblowing. The cases of BBH and MHS are examined here in this context.

Research design

The social phenomenon of nurse whistleblowing is examined with reference to the BBH and MHS cases. When organisational structures and conditions that can influence the phenomena under study occur, it is important to examine more than one case; this ensures that evidence generated is robust.[24] Publicly accessible documentary evidence was used for analysis here, including 7000 transcript pages, 511 exhibits and 29 submissions from the Bundaberg Hospital and Queensland Public Hospitals Commission of Inquiry (QPHCI),[25] and 767 pages of transcript from the 6 days of public hearings and 3 days of public forums of the Special Commission of Inquiry into Campbelltown and Camden Hospitals; the NSW Parliamentary Inquiry into Health Complaints[26] and the Independent Commission Against Corruption (ICAC)[27] investigation of the alleged mistreatment of nurses; and alleged misconduct relating to the former South Western Sydney Area Health Service.

Further analogical evidence included journal articles, transcripts and podcasts of radio and television broadcasts, television programme online forums, local, regional and national newspaper articles, books, movies and Acts of Parliament; Internet sources from professional and lay organisations provided a rich background of social conditions and factors influencing contemporary behaviours. All data were assessed and employed according to the requirements of unobtrusive research methods and secondary data analysis. Unobtrusive research method is the collection of data without the knowledge of the participants generating the data.[28] Secondary data analysis employs existing sources of written and audio–visual material accessed via public archives 'to answer a different research question than intended by those who collected the data'.[28,29]

Data were analysed using the basic schema of Critical Social Theory developed by Brian Fay.[30] Documentary evidence from the commissions of inquiry and other analogical evidence was examined for explanations of the causes and nature of (1) the 'self-(mis)understandings', (2) the crisis in the social system, (3) the theorised conditions required for transformative action and (4) the resolution of the social crisis.[30] Documentary assessment[29,31] and thematic analysis[32–34] were also applied.

Findings

Drawing on developments in cognitive neuroscience and psychology, Heffernan[20] argues that individuals treat incoming information differently depending on how it fits their existing, firmly held belief systems. The psychological concepts of 'motivated reasoning' or 'confirmation bias' explain how emotions influence decision-making as individuals selectively process information in order to support preconceived conclusions.[35,36] This is especially pronounced when a person is wedded to certain unshakeable core

beliefs, even dangerous convictions, that they are unwilling to relinquish, despite rising contradictory evidence.[20]

BBH case

In 2004, BBH (136 beds) provided emergency medicine, general medicine, general, orthopaedic and vascular surgery, as well as clinical services in renal dialysis, obstetrics, gynaecology, paediatrics, intensive care and coronary care to a district population of 87,933 covering the 12,590 km^2 of the Wide Bay, Central and Northern Burnett Regions of Queensland.[37–39]

The BBH case provides several distinct examples of wilful blindness and motivated reasoning, some of which will be examined here. The conditions contributing to whistleblowing in Bundaberg began when the hospital was unable to source adequately skilled surgeons to meet clinical demand. Dr Jayant Patel gained registration as a medical practitioner in Queensland under Queensland under Medical Practitioners Registration Act 2001 (QLD) Section 135, allowing overseas-trained medical practitioners to work in 'areas of need'.[40] When applying for registration, Patel failed to disclose disciplinary outcomes from two previous medical licensure boards in the United States and an Oregon Board of Medical Examiners' order limiting his surgical practice.[40] Patel was appointed Director of Surgery at BBH and employed between April 2003 and April 2005,[25] during which time he saw 1457 patients, operated on approximately 1000 patients and performed 400 endoscopic procedures.[25] From as early as May 2003 until his departure, nurses from the surgical wards, operating theatre, renal unit, infection control and intensive care unit (ICU) raised concerns about Patel's surgical competence, rates of post-operative complications, lack of infection control measures and decisions to perform complex surgeries rather than transfer deteriorating patients to more adequately equipped hospitals in Brisbane.[25] The nurses supplied written and verbal complaints, completed incident and sentinel event forms, raised concerns in management meetings and gathered evidence supporting their claims. Despite these complaints, there was no action from the BBH Executive or from senior officials of Queensland Health to evaluate and credential Patel's performance. The nurses' failed efforts in the face of systemic inaction ultimately led to an ICU Nurse Unit Manager (NUM), Toni Hoffman 'blowing the whistle' about the patient safety issues.

Perhaps the most obvious evidence of wilful blindness and motivated reasoning was seen in the reluctance of the Director of Medical Services to acknowledge that Patel should not have been performing complex surgical procedures at BBH and that his (lack of) surgical technique had led to an increase in the surgical complications. Within 6 weeks of starting work, Patel performed his first oesophagectomy – a complex surgical procedure not usually performed at BBH due to lack of specialised post-operative ICU facilities and staff (Exhibit 4).[41] The ICU at BBH had only five combined intensive/coronary care beds and was classified a Level One Unit; as a regional hospital, BBH 'should only keep patients who required ventilation for between 24 and 48 h before transferring them to a better equipped hospital' (Exhibit 4).[41] At the time of these procedures, post-operative management of elective surgery patients who underwent oesophagectomy recommended ICU management for at least 24–48 h, even without complications.[42] Complication rates for oesophagectomies are high; patients often have comorbidities and the surgery is technically complex.[43] The first patient to undergo an oesophagectomy performed by Patel (Patient P34 in the QPHCI), had pre-existing renal failure and later died in ICU from post-operative complications. The second patient to undergo an oesophagectomy (P18) – 18 days after the first death – remained in BBH ICU for 14 days, returning to surgery three times to treat complications, before being transferred to the Mater Hospital Brisbane (Exhibits 4 and 218).[41] The decisions to perform the surgeries at BBH and the post-operative management of patients were of such concern to ICU NUM Hoffman that she emailed her first written complaint to the Director of Medical Services:

> I am writing to inform you of the situation that currently exists in ICU with the post –op patient [P18]. As you are aware [P18] underwent an oesophagectomy on the 6th June. He subsequently returned to theatre twice for wound dehiscence. He again returned to theatre last evening for repair of leaking jejunostomy[. . .]. I am writing due to my continuing concern over the lack of sufficient ICU backup to care for a patient who has undergone such extensive surgery. Both the RBH [Royal Brisbane Hospital] and PAH [Princess Alexander Hospital] have expressed concern about this surgery being done in our facility, without this backup . . . The ongoing issues regarding the transfer of patients and the designate level of this ICU may need to be discussed in more detail at a later date. The behaviour of the surgeon in the ICU needs also to be discussed, as certain very disturbing scenarios have occurred . . . [41] (Exhibit 4-TH3)

On arrival to the Mater Adult Public Hospital in Brisbane, P18 was accepted into the ICU by the Director of Adult Critical Care Services. Following a review of P18 and surgical management at BBH, the Director of Adult Critical Care Services expressed immediate concerns about clinical practice at BBH, specifically, the capability of the ICU to manage such complex post-operative cases, and the accreditation and recent experience of the surgeon who had performed the operation (Exhibit 218).[41] The Director of Adult Critical Care Services contacted the Director of Medical Services at BBH outlining his concerns and followed up with written notification to the Mater Hospital's CEO, to be forwarded to Queensland Health Southern Zone Management Unit. The Director of Adult Critical Care Services at Mater Adult Public Hospital proposed a 'two-fold approach focussing on the role delineation of the hospital and the accreditation of the surgeon' (Exhibit 218, Appendix A2).[41]

Despite this, no action was taken by the Director of Medical Services at BBH to review Patel's competence to perform such complex surgeries, nor did he acknowledge that the ICU lacked the capacity to manage such post-operative cases. The final QPHCI report shows that the Director of Medical Services did not respond to either ICU NUM Hoffman or the Director of Adult Critical Care Services at Mater Adult Public Hospital regarding their concerns.[25] Instead, 'the oesophagectomies continued. Two more surgeries would be performed by Dr Patel at the Base [BBH] (each with a terrible outcome) before the issue was re-visited'.[25]

The BBH Director of Medical Services appeared adamant that the increasing number of complaints resulted from interpersonal conflict, a view supporting his own apparently preconceived conclusion that the complaints were unjustified. He submitted evidence of his thinking at the time 'the number of the complaints compared to the volume of patients he [Patel] was seeing did not cause me any concern' (Exhibit 448).[41] He remained resolute in this conviction even as late as December 2004 when he drafted papers to extend Patel's contract as Director of Surgery until March 2009. In that document, the Director notes Patel's 'contribution to increasing the surgical activity levels, outpatients scheduling, and endoscopy procedures, and [his] excellence in achieving the extra elective surgical targets' (Exhibit 448-DWK67).[41] The Director selectively noted only positive aspects of Patel's performance as indicative of his abilities (Exhibit 448)[41] and was 'wilfully blind' to the emergent documentation of surgical complications, wound dehiscence, sentinel event outcomes following complex surgery and Patel's reluctance to transfer seriously ill patients to tertiary hospitals in Brisbane. He apparently believed that 'a large number of staff [were] actively undermining the continuing efforts of Dr Patel to provide a general surgical service to the people of Bundaberg' (Exhibit 448-DWK66).[41] This suggests that the Director was only acknowledging information about Patel that justified his own judgements and that supported his delay in dealing with the previous complaints and incident reports. The Director's wilful blindness resulted in him filtering out unsettling information about surgical complications which contradicted his firmly held conviction that Patel was a capable Director of Surgery who contributed to the financial rewards from extra elective surgical funding from Queensland Health.[44] The human desire to avoid complaints that have a potential to impact on funding and negative publicity that will adversely affect reputation of the hospital is strong[45]

The nurses were aware of the Director of Medical Services' motivated reasoning, reporting that he 'preferred the version given by Patel over that given by the nursing staff' in relation to infection and other complications in the renal unit (Exhibit 59).[41] Wilkinson et al.[45] in examination of the BBH case suggest that the internal voices of doctors were valued higher than those of nurses. The Director asked nurses to provide further evidence to support their contention that Patel lacked skill in inserting peritoneal dialysis catheters, specifically requesting data on 'Patel's adverse events for renal procedures compared to his non-adverse events' (Exhibit 139).[41] Nurse Pollock, who had already provided the Director with a 'Peritoneal Dialysis Catheter Placements – 2003' report outlining a 100% complication rate for Patel's patients, wondered 'What more proof did he need?' (Exhibit 70)[41]

These demands for further evidence are consistent with motivated reasoning described by Helzer and Dunning,[35] where individuals favour evidence that supports their favoured conclusions and 'when it comes to conclusions they would rather avoid, they show a marked tendency to demand more evidence and to place whatever uncongenial evidence they have under intense scrutiny' (p. 7).[35]

Helzer and Dunning[35] explain further the power and risks associated with motivated reasoning by suggesting that 'the conclusions that people reach often [lie] some distance from objective truth or an impartial reading of the evidence . . . [and] motivated reasoning allows them to cling to favoured beliefs and attitudes'.

Two other managers – the District Manager and Director of Nursing – also demanded additional evidence from the nurses, rather than investigate the root cause of the concerns raised. Nevertheless, as with the Director of Medical Services, even after their receipt of such evidence, they took no action to address the nurses' concerns.

MHS case

Macarthur Heath Service (MHS) during 2003–2004, consisted of Campbelltown Hospital, a 320-bed Level 5 major metropolitan facility and Camden Hospital, a 84-bed Level 3 district hospital facility.[46,47] The MHS provided clinical services such as emergency, maternity, paediatrics, intensive care, cardiology, gynaecology, palliative care, respiratory care, stroke management and surgery, as well as broad aged care services.[47]

On 5 November 2002, four nurses from Camden and the Campbelltown Hospitals became 'whistleblowers' when they met with the NSW Health Minister. The nurses reported episodes of substandard clinical practice resulting in patient death and injury and expressed their dissatisfaction with the clinical governance processes at MHS.[46,48] The MHS nurses suggested that concerns reported through conventional channels during the period 1995–2002 failed to evoke adequate responses.[46] Instead, increased surveillance was employed to examine the performance of the whistleblowing nurses, who faced various forms of disciplinary action. The nurses' efforts to highlight systemic inaction in dealing with their concerns and the unjust management of their own cases, was each time referred back by the Department of Health or Health Minister to the Executive of the hospital, who appear to have been in denial that a problem existed.

The MHS case also presents examples of wilful blindness, and one such example is provided here. It involves the actions taken by the General Manager of MHS following a series of allegations and counter allegations of bullying and harassment stemming from conflict between two Campbelltown Clinical Nurse Specialists (whistleblowing nurses Quinn and Owen) and an anaesthetist in the organisation over patient safety matters.[46] The conflict began when the nurses questioned whether an elective operative procedure on a 10-year-old child should proceed. The nurses were concerned that safety precautions had not been addressed, including conducting an assessment of the patient to rule out malignant hyperthermia, ensuring proper preparation of anaesthetic equipment, availability of medication to treat malignant hyperthermia and, finally, that a more senior anaesthetist be onsite to deal with the case in the event of complications.[46] MHS management largely ignored evidence of circumstances that would explain the nurse's behaviour and

their attempts to advocate for patient safety, instead chose retaliatory action against the nurses. In each reported case, managers sought to confirm and reinforce their perception that the issues were not patient safety breaches, but personal conflict emanating from the reporting nurses. The General Manager of MHS commissioned an external review by a retired senior nursing administrator.[46] The Stow Review included a confidential survey of 60 staff who were not informed that the data would be used as a central piece of evidence in a disciplinary investigation.[46] Neither Quinn nor Owen was offered an opportunity to complete the survey, nor were they interviewed by Stow prior to her tendering her report.[46] On receipt of this report, the General Manager of MHS escalated the findings to the Area Health Service requesting an examination in light of alleged corruption. In concluding that, the report was inadequate, the Director of Internal Audit Services suggested that it contained significant emotional content and its 'use of the terms fraud and corruption were inappropriate'.[46] Despite this, the Stow Review Report was used. Quinn and Owen were subjected to further investigation and found to have breached the Health Service Code of Conduct. As punishment, their Clinical Nurse Specialist status was removed (a demotion in professional status). When confronted by conflicting evidence and the assertion by the Director of Internal Audit Service that the Stow Review was flawed, the General Manager of MHS had two choices: either acknowledge the unpleasant fact that hospital processes were not adequately protecting patients or reach the more palatable conclusion that the issue lay with 'vexatious' nurses making 'unsubstantiated allegations' of substandard care. The preferred option was to discredit the nurses rather than fully examine the human factors and processes underlying cause of conflict.

Nurse Quinn later reflected on her experiences of dealing with management at MHS to the Legislative Council of Government investigating complaints handling within NSW Health: 'Unfortunately, the pursuit of my concerns led me to being shackled by management and thrown on the scrap heap' (Quinn Evidence, 12 March 2004).[49]

Implications for nursing management

The examples of wilful blindness found in the BBH and MHS cases show the perils that can result when leaders and managers receive reports of patient safety concern. As outlined by Duckett,[50] the 'critical issue in Bundaberg was not a problem of identifying aberrant poor practice but rather of acting on this knowledge'. Leaders and managers appeared to seek out additional evidence which supported their view that there were no patient safety breaches or organisational failure within the organisation. Nurse whistleblowing would not have occurred if those within the organisation responsible had actively listened to the messages of failure and adequately addressed them.

In BBH and MHS, addressing staff concerns placed the leader at odds with the competing interests of the organisation and/or powerful vested interests within it. In such cases, leadership requires moral courage. Moral courage is defined by Hutchinson et al.[51] as 'worthy actions taken by leaders in support of fundamental values that are enacted in the face of actual or potential personal risk or cost'. It includes actions of speaking out and bringing issues into the public where they can be scrutinised.[52]

Moral courage requires personal awareness of competing emotions when responding to ethical challenges.[53] This level of personal awareness is described by Hutchinson et al.[51] as skilful moral discernment which includes an 'ability to evaluate complex situations', but also make judgements and demonstrate a clear appreciation of the human reaction to conflict and competing interests. Understanding the features of wilful blindness and the human tendency to favour positive news and avoid conflict can guide leaders to make overt efforts to individually and collectively address blind spots.[54]

It is acknowledged that the BBH and MHS cases occurred a decade ago, nonetheless there is evidence of continued inadequate clinical governance; when monitoring and responding to reports of adverse clinical outcomes are not actioned, problems continue to arise. This can be seen in the Duckett Review of Hospital

Safety and Quality assurance in Victoria[55] of a cluster of perinatal deaths at Djerriwarrh Health Services in Bacchus Marsh, Victoria, during 2013 and 2014. What has been learned from all these cases is that when nurses and other health professionals report concern, they do so within a social structure where politics and power are constantly in play. Such contextual considerations contributed to the BBH and MHS cases and their aftermath.

Heffernan[20] in her recommendations to counter wilful blindness acknowledges that 'context counts'. There are organisational structures and cultures that create environments favourable to wilful blindness, particularly where there is a high focus on the power and influence of individuals. In both BBH and MHS, executives and leaders engaged in what Heffernan described as 'second-guessing' which prevented them from focussing on or analysing what was actually occurring. For the executives at BBH, acknowledging that a Director of Surgery was unable to self-manage his choice of surgical cases, consider his own scope of practice and the limited resources available in a regional healthcare setting, was too difficult to accept. Jackson et al.[19] identify this as 'avoidant leadership' and find that it takes three forms: placating avoidance: leaders acknowledge the concerns but then take no action. Equivocal avoidance: leaders show ambivalence and ineffective action. Hostile avoidance: leaders not only fail to address concern but also actively exculpate those at the centre of the concern and direct hostility towards those who report.[19] The latter was clearly evident in the MHS case.

Wilful blindness in the face of reports of wrongdoing can be avoided, as it is possible for a leader to find the truth. However, in the face of actual or potential personal risk or cost, there is also a competing 'motivation or incentive to fail to learn the facts'.[56] Lynch[56] describes wilful blindness or ignorance as occurring when 'unwelcome evidence exists or potentially exists', yet the leader avoids 'exposing himself [*sic*] to it'. In the BBH case, the perverse response of ignoring emergent evidence related to the financial incentives at play.[50] The human reaction of avoidance in these circumstances to deal with conflict by 'imagining it out of existence' is strong.[20] It was easier for the leadership at BBH to imagine that the conflict and concerns raised about Patel were motivated by his behaviour rather than his competence as a surgeon.

The positive news about the nature of wilful blindness is that it can be countered. For Cornwell et al.,[53] in their examination of avoidance behaviours in the face or moral conflict, a unique feature of being human is the capacity to perceive singular actions or inactions, approaches and avoidances, and to then 'act or inhibit their behaviour in order to close the gap or maintain the concordance between their actual selves and their ideal- or ought-selves'. Heffernan[20] recommends that to avoid wilful blindness, leaders must actively seek disconfirmation and 'drive for a full story'. Leader inclusiveness has also been recommended as a strategy for seeking disconfirmation and creating a workplace with psychological safety. For Edmondson et al.,[57] psychological safety is the 'degree to which people view the environment as conducive to interpersonally risky behaviours like speaking up or asking for help'. In all work environments, learning from those who do speak up matters. Nembhard and Edmondson[58] suggest that this learning occurs when leaders include others in discussions and decision-making, ensuring that all voices are heard. Research into psychological safety has found improvements when leaders take action to reduce the status gaps between themselves and other healthcare professionals.[57] One action proposed to close gaps and promote availability is executive work-arounds, which research has shown to improve perceptions of a safety culture.[59]

Conclusion

The development of healthcare systems that satisfactorily deal with patient safety is an ongoing endeavour. This study recommends a refocussing of attention and research, not only on clinicians at the coalface of patient care but also on the leaders and managers who receive reports of failure in patient safety provision. The human reaction or reflex to avoid conflict, to favour interests that deflect reputation risk to the organisation and their own leadership is strong, can result in direct hostility towards those who report wrongs.

The call to action here is for those leaders who receive reports of patient safety breaches and concern from staff to develop an awareness of the perils of wilful blindness and take active measures to seek disconfirmation and examine the full story. Where evidence of misconduct emerges, leaders must demonstrate moral courage, must act on reports of patient safety concern, despite personal and professional, internal or external pressures to remain blind and or silent.

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