

Wilful blindness is bad for the health

By Roger Kline

According to British MPs, Rupert Murdoch, media mogul, stands accused of having "turned a blind eye and exhibited wilful blindness to what was going on in his companies and publications".

'Wilful blindness' is the title of an [excellent book](#) about whistle-blowing by Margaret Heffernan. The book explores a theme that is not confined to newspaper or media barons but lies at the heart of the failure by too many staff in health and social care to raise concerns, and whistle-blow, when they should. It is central to the failure of organisations across health and social care to do the right thing and create a climate in which raising concerns and reporting mistakes is a natural part of improving the standard of services and care.

Lessons not learned

A decade ago the report of the [official inquiry](#) into care at Bristol Royal Infirmary, where up to 100 babies were estimated to have died unnecessarily, described the climate of fear that prevented health care staff from reporting concerns. In its wake a raft of welcome initiatives followed. Clinical governance provided a framework of accountability for driving up quality and encouraging staff to raise concerns. The National Patient Safety Agency set about encouraging hospitals to report incidents and 'near misses'. Major research was commissioned and demonstrated the benefits for patients of a more open, collegiate and transparent culture. Whistle-blowing procedures blossomed across the health service and local government.

Yet a few years later, at Mid Staffordshire hospital, another scandal erupted after it was revealed that there had been between 400 and 1,200 more deaths there than at comparable hospitals. That experience suggested that the lessons of Bristol were ignored in an

Public World associate [Roger Kline](#) has led the way in promoting the responsibility of health and social care workers to maintain a 'duty of care' to those they look after.

Crucially, he insists that their responsibilities require that the whole organisational and management culture not only requires but also enables them to exercise that duty.

outbreak of 'wilful blindness'. When the [Inquiry Report](#) by Robert Francis QC into the Mid Staffs disaster is published in October it will be surprising if it does not make this point.

Most of us do not want to collude in what we know to be wrong. But in Britain's NHS today, challenging wrongdoing by raising concerns and reporting mistakes can take remarkable courage.

In the best organisations, those charged with leading the organisation welcome challenge because it helps the organisation to learn. But the recent history of the NHS is littered with the casualties of the fear of acknowledging error, especially where such errors might be the tip of a very large iceberg, in an organisation that is systematically flawed.

Sharmila Chowdhury, Kim Holt, Margaret Heywood, Rahon Niekrash, Gary Walker, Steve Bolsin -- the list of those who have had the courage to blow the whistle is a long and honourable one. The reports of [Public Concern at Work](#) and the recent experiences of members of [Patients First](#) are a litany of such wilful blindness.

In his [first speech](#) after taking up the post in 2010, Secretary of State for Health Andrew Lansley said the NHS must move "from a culture responsive mainly to orders from the top down to one responsive to patients, in which patient safety is put first". Yet there is virtually no sign of measures to improve accountability, beef up clinical governance, hold chief executives to account for systemic quality failures, or better prevent whistle-blower victimisation.

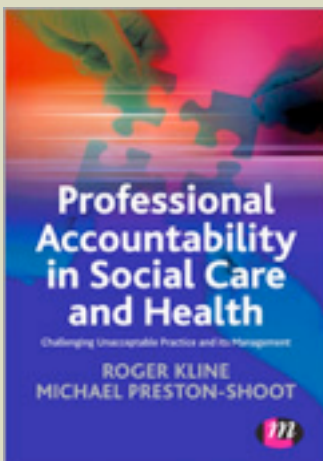
The damning verdict by MPs on Rupert Murdoch's wilful blindness should be a reminder to us all. Looking the other way is bad for your health and that of others, and workplace cultures that allow that to happen are unhealthy for all who come into contact with them.

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34b York Way,
London N1 9AB**

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