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Book Chapter

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Whistleblow or Walk on By? Ethics, and cultures of collusion in health and social care

1. Whistleblowing and the ethical void

Raising concerns – whistleblowing – about the quality of care provided in health and social care services is not always action advised for faint-hearted professionals. Despite a statutory duty of candour on professionals registered in England (CQC 2015); regardless of professional obligations built into the requirements of formal registration and statutory regulation of professionals (GMC 2014; CCW 2015; NMC 2015); and notwithstanding legislative protection for those making protected disclosures in the public interest under the UK's Public Interest Disclosure Act 1998 (PIDA), the fate of many who have drawn attention to shortcomings, failures or dangers in health or care delivery is salutary. Outcomes such as victimisation, the loss of livelihood, health, family and career, and thoughts of suicide, are not ones anyone would sensibly wish for themselves or others speaking up about poor practice (Kmietowicz 2015). To walk on by, rather than whistleblow, may start to look like a rational response to the irrationality of these retributions.

Retrospective inquiries and investigations into disasters such as that reported in the public inquiry into England's Mid Staffordshire NHS Foundation Trust (Francis Report 2013), tragedies such the unnecessary death or brain damage suffered by children undergoing heart surgery in Bristol Royal Infirmary (Kennedy Report 2001), or the abuse and mistreatment of people with learning disabilities in Winterbourne View, England (SGASB 2012), have often depicted the same themes, even though time and place has differed (Ash 2014). That sameness has included, depressingly, the

following: some staff raised concerns about poor or dangerous practice but these were ignored and they were marginalised, scapegoated or blamed; the poor practice was, or became, normalised and people stopped noticing; routine regulation and inspection by myriad bodies failed to recognise or react to information that clearly should have given cause for concern.

This wider system failure – an ethical void – in the care and treatment of people at their most vulnerable, needing medical, health and social care at times of life where they may be in pain, in trauma or near to death, is encapsulated in muddles of action, inaction, blame and retaliation that disasters and tragedies in health and social care lay bare. Despite protection that statute is supposed to provide to those who make protected disclosures in the public interest under whistleblowing legislation it seems, in cases where things have gone badly wrong, that health and social care management, leadership, regulation and inspection systems have seemed driven to blame, cover-up and close-down when things go wrong.

It is also clear that the culture and power dynamics in these settings have a superordinate influence on the way individuals behave and respond to something causing them concern. Fitting into the team, being a team player, turning a blind eye to poor practice to get the job done, are all social responses of the person to a situation they find themselves in (Ash 2013; Ash forthcoming). Inquiry after inquiry has described the influence of the contexts and cultures in which people have worked on how they have done their work (for example, Kennedy Report 2001; Francis Report 2013), yet most have side-stepped the messy business of deconstructing the regulatory and policy apparatus to better understand its unintended, negative consequences on professional behaviour. Blaming an individual without looking at the context to their behaviour is like blaming a farmer for crop failure, without considering the weather.

This paper makes a case for embedding ethical behaviour – right action – throughout the health and social care systems that the patient or service user, employees, managers and leaders, as well as the whistleblower, find themselves in. It is argued that to whistleblow, or to walk on by, are moral actions, with moral consequences. Expecting professionals and staff to discharge their obligations and duties as health or social care workers impeccably, in organisations, service systems and units that are managed and led politically in ways that are anything but just and impeccable, is an ethical double-bind. Patient lives may be avoidably lost, professionals may contemplate taking their own lives under the stress of investigation (Bourne *et al* 2015).

This discussion takes as its starting point the futility or, worse, the danger posed by cosy conclusions of lesson-learning and standard-tightening that so often follow inquiries, reviews, whistleblower sackings and justifications thereof. In particular, this paper develops the case for considering how elements of an ethic of care – as originally put forward by Berenice Fisher and Joan Tronto, and developed subsequently by Tronto (Fisher and Tronto 1990; Tronto 1993; 2013) – might be embedded into ethically-driven health and social care service systems, policy and practice that would expect and support staff and service users to raise concerns and blow the whistle, when necessary, rather than walk on by.

This paper considers whistleblowing in health and social care services in the UK. Four substantive parts follow this introduction.. The next section sets out the broad context to the paper's argument and discusses the social, interpersonal and relational dimensions of morality and ethical action in health and social care. It considers what it is to act with integrity, above and beyond the exigencies of professional codes of practice. The third section considers the act of whistleblowing as an ethical challenge

to power and organisational privilege, as well as poor professional practice. The cases of two whistleblowers in England are discussed, and moral dimensions of the action they took are identified. Fourth, elements of Fisher and Tronto's (1990) ethic of care are considered, and the case made for these four elements – attentiveness, responsibility, competence and responsiveness – to be hard-wired into health and social care systems. The fifth section maps out, in a practical way, how an ethic of care might manifest at three conceptual levels in health and social care systems: one-to-one care and treatment; at the organisational level; and at the wider regulatory, policy and political level. Lastly, and overall, the paper argues that the question 'whistleblow or walk on by?' is a moral question.

2. Ethics in context

Many people working in health and social care, and not only the whistleblower, will hear, see and witness poor or corrupt practices that, if attended to and acted upon, could provide organisations with the early warning that systems, structures and processes are not working as they should (Ash 2013). In drawing attention to the wrong and trying to have it put right, the whistleblower can teach the organisation something about itself. Except, of course, the organisation and its political backcloth have to be open to learning, to hearing, attending to and making changes. That wider context, the all-enveloping situation that surrounds what doctors, nurses, healthcare professionals, social care and social workers do, profoundly shapes and constrains how they do their work. Looking at that bigger organisational and political picture, with a sharply critical eye, has to be crucial to commentary on whistleblowing and the experience of whistleblowers who speak out, and who frequently take the hit for their trouble, be it loss of financial security, career, relationship, family, health.

From a social, or collective, perspective, Rest regarded morality as a 'particular type of social value, that having to do with how humans cooperate and coordinate their activities in the service of furthering welfare, and how they adjudicate conflicts among individual interests' (Rest 1986, p.3). This gets to the *relational* nature of morality – to collaboration and cooperation to do good, as well as to resolution of individual interests and conflicts. People work with people to deliver health and social care to those who need it. They engage in relationships that are defined by certain values. People learn to understand each other and express those understandings in what Walker (2007, p.10) called 'practices of responsibility'. These responsibilities may be accepted or deflected. Morality is present, part of, and exists within practices that show what is valued. These practices involve making moral judgments of each other, of paying attention, visiting blame, making excuses, making amends: all ways in which we express senses of responsibility.

In this way, morality is fundamentally *interpersonal*. Morality makes people accountable to each other. It exists in real space and real time, between real people. It is present and part of everything that happens in health and social care (Ash 2010). Moral knowledge is co-created in relationship with others. It is produced, reproduced, and modified in what goes on between or among people, whether at home, in the workplace or anywhere people act and interact together. Morality is *collaborative*: what transacts and passes between people is formed, de-formed and made intelligible by common understandings of what people do, are supposed to do, and what can be expected from others, individually or collectively (Walker 2007).

Cracking the integrity codes

The public expects healthcare and social care workers to act with integrity. Statute demands that registered professionals comply with their professional code of practice.

These are similar but they are not the same; the former is far wider than the latter. The word integrity, from the Latin *integritas*, means soundness, uprightness and honesty, and 'wholeness' without any part removed or taken away. It's the real deal; the whole thing. To act with integrity brings up some deeply moral questions.

Banks (2010) identified three versions of what it is to act with moral integrity in professional life. First, integrity is the conduct and compliance of the individual with their professional code, the guidelines or rules of the profession. These provide some 'do/don't' rules to follow, important insofar as they guide, give direction and offer some public protection, but dangerous when those tasked with compliance become unthinking rule-followers, box-tickers or jobsworths without the skill or will to question more deeply the impact of those rules on themselves or people they are paid to care for, support or treat.

Second, Banks suggested integrity could be understood as 'standing for something', that is, showing commitment to particular values and principles in a social context. In this, the individual is tasked with the commitment, but the situation and social context in which they are expected to deliver that commitment remains unexamined and untouched. It may manifest deeply iniquitous structural features that render ridiculous the individual's efforts to conduct their work with integrity. The person may become burned out or uber-zealous in the process of trying to resolve structural problems through individual effort.

Thirdly, Banks described moral integrity as a capacity to think about and make sense of the continuous, dynamic and ever-present nature of the world. This capacity is not the static structure of the 'good self', but is reflexive and evolving. Again, the organisational or social situation within which this capacity is exercised itself requires

reflection and examination. Banks believed all three elements of integrity overlapped. They were not linear, sequential or either/or.

Banks (2014) suggested ethics, which are located in the lives of people, and situated in human and social relationships, embrace four dimensions: conduct (actions and behaviours considered right or wrong); character (moral qualities viewed as good or bad); relationships (responsibilities attached to relationships between people, communities, others); and the good society (where people are free and flourish harmoniously with other sentient beings in their shared natural environment).

In health and social care, codes of conduct and statements of ethics typically collapse these four dimensions into knowledge and competence, and respect of individual rights and choice (even though the resources necessary to realise those rights may be lacking) (GMC 2013; CCW 2015; NMC 2015). In doing this, codes mainly aim to prevent harm, rather than *promote* rights, care or ethical practice (Banks 2014). They are bottom lines, not top notes. But ethical practice is more than simply following rules; it is reflexively engaging with those rules to keep the *point* of the rules to the fore – the wellbeing, health and care of the other person.

3. The whistleblower's ethical challenge

Whistleblowing is a political act: the whistleblower challenges power and, sometimes, privilege. Practices that whistleblowers draw attention to are positioned in a professional world shaped by public policy and regulation, and human engagement and activity in it. The whistleblower may raise concerns about practices that may be illegal, pose risk to people or the natural world, or cause suffering to others. In this, the act of whistleblowing seeks to stop or put right the wrong, and to seek justice.

Many stories of whistleblowers have a familiar story arc: the employee raised concerns; the concerns were ignored so the person raised them again; the person making the disclosure was marginalised or victimised in the workplace; they suffered professional and financial detriment; the employee lost their job and, very likely, the possibility of working and progressing in their sector, workplace, profession again (Hammond & Bousfield 2011; Smith 2015).

Two NHS (National Health Service) cases in England illustrate this, those of consultant doctors David Drew and Raj Mattu. David Drew, a consultant paediatrician in the English Midlands who spoke out about a child safeguarding matter and about shortcomings in patient care, was eventually sacked. In his account, Drew (2014) described raising concerns about child safeguarding arrangements and the unlawful killing of 16-month old Kyle Keen, and about the very low ambient temperature in his hospital ward for newborn babies and sick children.

To raise these concerns, Drew had to first of all to *notice* what was going on. He had to *pay attention* to sick and vulnerable children he was paid to treat and to serve. To care enough to treat the sick, and to raise concerns, Drew had to respond to their needs, to display and act with *responsiveness* as an experienced clinician. And Drew had to be *competent* in his practice. He had to have the integrity, grit and the sheer guts to raise, and keep on raising, concerns: he had to act with *responsibility*.

Raj Mattu, a consultant cardiologist, also in the English Midlands but in a different health Trust area, also blew the whistle, in his case about overcrowding in hospital spaces designed for four cardiology beds, not five as he discovered was the practice. Mattu was concerned that because the number of beds in these cubicles was five not four, patient safety – human life – was compromised if equipment such as oxygen or mains electricity could not reach the fifth bed.

Prior to Mattu's disclosures, the Commission for Health Improvement[1] (CHI) had reviewed this particular service. CHI criticised 'the unacceptable risk to patients of putting five beds in bays designed for four', and it reported that senior staff felt intimidated about reporting their concerns (CHI 2001, p.vi; p.vii). When the hospital Trust's chief executive rejected the CHI findings, Dr Mattu made a protected disclosure under PIDA– he blew the whistle. As is often the case, a counter-allegation (of bullying) was made against Mattu, who was suspended from work, his public interest disclosures rebadged as employment matters and thus falling outside whistleblower protection, such as it is, afforded by PIDA. This one counter-allegation snowballed to over 200, all of which, eight years later, were found to be false. In April 2014, 13 years after Mattu first raised his concerns, an employment tribunal awarded Mattu compensation (Smith 2015).

These are two cases where clinicians acted ethically in response to clinical concerns about potential or actual risk and danger to people they were professionally charged to care for. The ethical dimensions of their actions were eclipsed by concerted retaliation by their employers and the lawyers they hired, at public expense and over many years, to silence these doctors. Both doctors acted in line with the requirements of their registration as medical practitioners, that is, to take prompt action when patient safety was seriously compromised. They were, in other words, doing their job, taking right action. Those right actions (no matter what procedural niceties either doctor may have gotten wrong along the way in drawing attention to these problems) cannot not be sustained however, when the system surrounding them extinguishes ethical expression, denies the undeniable, or substitutes sense with soundbite (as when 'we take patient safety very seriously' becomes bland cliché).

4. An ethic of care

Both the cases of Drew and Mattu involved their paying attention or noticing, their caring enough to respect, respond and act, and their being competent to know what should or should not happen in those situations. Those qualities are ones which Fisher and Tronto (1990) located in their particular development of an ethic of care.

From their broad definition of care as a 'species activity that includes everything that we do to maintain, continue and repair our "world" so we can live in it as well as possible, that includes our bodies, ourselves and our environment, all of which we seek to interweave in a complex life-sustaining web'(Tronto 1993, p.103), Fisher and Tronto's identified four elements of an ethic of care. Each of these elements can be recognised in the cases of Drew and Mattu above, as well as of other whistleblowers across different sectors, not only health and social care.

The first element of an ethic of care is *attentiveness* – paying attention to what is happening, to the needs of the other, to the impacts of actions and inactions on another. In a moral framework, not attending, in these and other ways, becomes a moral failing. The second element is *responsibility*, that is, the ability to respond to the needs of others within the cultural practices that pertain, rather than just obeying rules, following orders and meeting rulebook obligations. The third element, *competence,* is necessary to provide care and to take care of – incompetent care is a moral failing, whatever the intention. The fourth element of an ethic of care is *responsiveness*, of and between the care-giver and care-receiver. If we need care we are, at that moment, vulnerable. How our vulnerability is responded to is a moral matter, with moral consequences.

This exposition of an ethic of care allows for thinking about care in a broad, public and relational way. Care is *action*, it is *relationship*, and it is care *with* and *for* each

other. The ethical qualities associated with ‘attentiveness’ require a suspension of self interest and the capacity to understand and pay attention to the needs of the other, responding to human need and being competent to care. It means caring for right action (Tronto 1995).

Where this ethic of care intersects with the whistleblower's dilemma lies in the interaction between the person needing care, and the organisation providing it. When the quality of care is poor or dangerous, alarm bells should ring. It is the whistleblower who often sounds the bell. Tronto (2010, p.163) identified a number of ‘warning signs’ that flag up poor functioning in care situations. Tronto was thinking about institutional care, but these red flags can be used to understand large-scale organisational functioning and behaviour across health and social care more widely.

One of Tronto's warning signs was an organisation that regarded health or care needs as fixed or given, rather than being personal, negotiated, relational, changing and context-dependent. At the stark, crude and readily recognisable end of a spectrum, are organisations (or local services within them) that are infected by callous, rigid, dehumanised practices, such as leaving older people lying in their own excrement or in hospital corridors (or both), ignoring requests for help with bodily needs and functions, calling patients by their condition or bed number, rather than by their name.

Another red flag for Tronto was the commodification of care, where care is reduced to a timed, standardised commodity – a ‘unit’ of care – rather than a transactional process within a relationship of power, dependency, need and vulnerability. Once care becomes commodified like this, scarcity, rationing and deficit-driven thinking quickly follow. They can result in the shocking parody of anything-but-care that are 15 minute hit-and-run domestic ‘care’ slots for a minimum-wage care worker to wash, dress and provide food and drink to an adult unable to do those things for themselves (Leonard

Cheshire Disability 2013). This debases care to a basic subsistence level of existence. It narrows care down just to care-giving, devoid of attentiveness, responsiveness or responsibility.

A further warning sign is pegging the wages of the lowest paid when organisations, faced with budget shortfalls cut care worker hours, or undercut UK minimum wage law by not paying the carer for travel time between one service user to another[2], rather than halting pay rises of managers and leaders, who are in any case likely to be paid 10 or 20 times the care worker's hourly rate. In a nutshell, as Tronto observed (2010, p.165), when 'care givers find themselves saying that they care despite the pressures and requirements of the organisation, the institution has a diminished capacity to provide good care'.

The making of 'bad apples'

These warning signs may be precursors of problems, shortfalls and deficits of standards and safety of health and social care that whistleblowers and others raising concerns are alert to. These are seldom isolated one-offs that the 'bad apple', sometimes bad 'barrel', accounts foreground in the public sorry-saying, lesson-learning and must-never-happen-again apologias offered up by leaders or politicians after failures of health or social care. These disasters occur in a context. They have social, cultural, political, economic backcloths – all wider, and mostly out of scrutiny when it comes to the 'name, blame and shame' of an individual or service. That infamous bad apple and its bad barrel don't spring from the ground like some alien life force. The bad barrel *makers*, to borrow Zimbardo's phrase (2007; 2008) are the regulatory, resourcing and organisational surrounds to health and care that are always, somehow, slightly out of shot when the picture of failure is presented for public consumption. Whistleblowing, and ethical action, exist in that context. Even if the

whistleblower doesn't walk on by from raising concerns, those surrounds can be the obstacle that trips them up.

5. Putting an ethic of care into health and social care

Fisher and Tronto's ethic of care had four elements, and it has been argued that whistleblowers who call attention to failures act in concert with each of them. So what might an ethic of care bedded into health and social care practice, organisations, and the wider political and policy system look like?

Figure 1 maps out Fisher and Tronto's four elements of an ethic of care, alongside three levels of health and social care systems. These three conceptual levels are first, the individual practitioner level, where the professional delivers health and social care to the patient or user of the service; second, the organisation that employs them; and third, the wider political, regulatory and policy system they operate within. These levels are not separate, discrete layers of operation; each intrinsically impacts on the other.

Attentiveness

The first element of an ethic of care is *attentiveness*. At the direct one-to-one health or care-giving, the practitioner and professional manifesting attentiveness would need to be alert to the needs of the patient or client of the service. That much is obvious, and is a requirement written into professional codes of practice and registration requirements for doctors, nurses and social care workers (GMC 2014; CCW 2015; NMC 2015).

Figure1. Mapping an ethic of care into health and social care

Level ➔	Practitioner[1]	Organisation[2]	System[3]
Element of an ethic of care ⬇			
Attentiveness	Alert to and attends to the needs of the person using health and social care services.	Attends to making and maintaining organisational cultures intolerant of poor or marginal quality care, and of not speaking out.	Attends to the impact of name, blame and shame cultures on the nature and quality of health and care delivered.
Responsibility	Style and approach shows an ability to respond to the individual health or social care needs of the person.	Systems, structures, processes and practices in the organisation underscore rules as the means, and not the end, of quality health and social care delivery.	Held to account for realistic resourcing of health and social care, for and supporting the routine raising of concerns.
Competence	Properly skilled to do the job, and show care in doing it.	Support, lead and manage services to ensure adequately-resourced employees can deliver competent support.	Fit-for-purpose law, statute, regulation, education and training of health and social care staff.
Responsiveness	Responds to risks of poor care. Speaks out about poor care.	Organisations walk the talk of self-challenge, critical thinking; expect reports of sub-optimal practice; are concerned if there are none.	Listen, protect and respond to the whistleblower. Criminalisation of retaliation against the whistleblower.

Developed from the original work of Fisher and Tronto (1990) and Tronto (1993).

[1] 'Practitioner' refers to health and social care staff, eg doctors, nurses, social workers, social care workers, who deliver one-to-one health and social care.

[2] 'Organisation' is the health or social care agency, eg, the NHS, private regulated health and social care services.

[3] 'System' depicts the policy, regulatory and political context to health and social care delivery.

Things get more tricky at the organisational level. Manifesting organisational attentiveness to human need requires a bit more than rules and procedures, as necessary as they are. Organisations that walked the talk of attentiveness would put effort into creating and sustaining organisational cultures that expected and supported its employees to raise concerns, give feedback and actively demonstrate, routinely, that they were paying attention to meeting needs. These would be organisations whose leaders and managers lived and breathed lesson-learning in real time by paying attention to how the needs of people using services they were paid to run were actually met. These would be places that, authentically, paid attention to what staff and patients and service users told them about their services. They would want their employees to raise concerns because they knew such concerns were often the early warning signs of potential system failure.

Within an ethic of care, the third, wider, regulatory and political system level would display attentiveness to the impact on patient care of name, blame and shame cultures that lead to defensive practice and to hedging decisions in medicine. A regulatory system working first and foremost from an ethic of care, would take steps to find out why it was that one in five doctors subjected to fitness to practice investigations by the General Medical Council (the regulatory body for doctors licensed to practise in the UK) felt victimised after whistleblowing, why 38 per cent felt bullied, and over a quarter had over one month off work (Bourne *et al* 2015). These are stark patterns calling for the *attention* of regulation and policy-making.

This wider system would pay careful attention to ask *why* billions of pounds of public money has been spent clearing up messes created because the concerns of people working in health and care weren't attended to earlier (Hammond and Bousfield 2011). Operating ethically, these would be regulators and policy-makers who paid

attention to disincentivising health and care organisations who opened 'their' (*sic*) wallet to pay top-end legal fees every time something went wrong.

Responsibility

The second element of the ethic care is *responsibility*. Outside ethics, and at its most reductionist, responsibility gets conflated with blame – you or they were responsible. Blame-finding relies on rules of evidence to show the connection between *x* and *y* and harm suffered, for evaluating intentions, motive and consequences. Blame-finding typically sidesteps the structural and social processes that constrain and influence people in the complex webs of unjust social structures. A blame-finding paradigm is often oblivious to those with the greatest power getting the greatest pay-off when things go wrong, usually far away from those who came to harm or who took the rap for it.

In an ethical frame, however, responsibility at the one-to-one level, is better understood as an *ability*, a style or an approach, of the health or care practitioner to *respond* to the needs of the patient or service users. At the organisational level, responsibility understood in this way would regard *rules as the means and not the end of good quality care*, and view a person raising concerns as acting responsibly.

At the wider system level, responsibility within an ethical frame would ensure realistic resourcing for organisations to discharge their responsibilities properly, and to be alert to shortcomings and 'near misses' in practice (Macrae 2014). This wider regulatory, policy or political system level would call to account organisations that threw money at silencing the whistleblower, by any legal means necessary, without checking if the smoke they drew attention to wasn't an out-of-control blaze.

Competence

Competence is the third element of an ethic of care. Like the other elements, this is obvious and easily understood at the individual level, the direct giving of health or social care. Competent staff are properly skilled to do the job, *and they demonstrate care when doing it*.

At the organisational level, competence within this ethical frame would include management and leadership that was fit for purpose in the delivery of health and care. That is, management and leadership that understood it was paid, first and foremost, to support health and social care delivery, to consider what competent professional told leaders, rather than simply servicing a complex, resource-devouring regulatory machine that was, in any case, just a means and most certainly not the end of high quality health and care delivery.

Competence displayed at the wider system level would find regulators, politicians and policy-makers reticent about over-claiming what regulation could achieve. Policy and regulation would ensure that fit-for-purpose statute, regulation, education and training of health and social care staff and those paid to lead and manage health and care services evolved, as patient and citizen needs and expectations changed.

Responsiveness

Finally, the fourth element of an ethic of care is responsiveness. At the person-to-person level, the worker manifesting responsiveness in this ethical frame would be alert to the human dimensions of health and care, such as the need for connection, kindness, respect and compassion. Responsiveness at the organisational level would be displayed, for example, in organisations that lived and breathed patient care, and who publically and openly valued staff and patients drawing attention to shortcomings in practice. These would be organisations where managers and leaders would perk up

if they *didn't* hear concerns raised, and would want to know why. They would be sharp enough to know that no news was not always good news, and would ask intelligent questions of the mass of data they collect, to find out what it could tell them about the quality, standard and patient experience of health and care delivered. They would be organisations whose first response to the whistleblower would be to listen intently, fact-find and assess; and not pour public money into paying legal fees to quash the whistleblower, come what may.

A political, policy and regulatory level that exhibited responsiveness within this ethical frame would effectively demand organisations better listen to, support and act on the concerns of whistleblowers. This systemic level would place legislation on the statute book to criminalise those taking retaliatory action against whistleblowers, to mark out an ethical space where wilful blindness to wrongdoing and organisational spite against those drawing attention to it were put beyond the pale of right action in public life.

6. Whistleblow or walk on by?

Without an ethical imprint throughout health and social care systems, the delivery of effective high quality care to people who need it, the response to whistleblowers and those raising concerns about that quality of health and social care, is likely always to fall back into defensiveness, blame and punishment. If wider health and care systems impede, block and obstruct a keen, dispassionate attempt to understand the problem and put it right, without first of all calling in the lawyers to nail the hapless whistleblower, then we are all whistling in the wind.

When this happens the collateral damage, the long-lasting impact on the whistleblower, on the person raising concerns, on those who bore witness but did not

speak out, as well as those who came to harm, lives on. This corrodes and corrupts the integrity of care delivery, and leans ever more harder in on individuals, teams and groups of people who day-on-day go the extra mile to deliver the best health and social care they possibly can. To rely on people to get round the system, rather than their being able to rely on *it* to support their work, is a curious corruption of morality and ethics. And it is the whistleblower who too often acts as the canary in the coalmine, so to speak, raising concerns when others walk on by. 'Whistleblow or walk on by?' is fundamentally a moral question, and it is one that demands a moral response.

Acknowledgments

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[1] The Commission for Health Improvement (CHI) was set up under the 1999 Health Act to review clinical governance in NHS bodies in England and Wales and carry out investigations of NHS health providers. CHI ceased operation in 2004.

[2] Gardiner, L (2015) *The scale of minimum wage underpayment in the social care sector.* London: Resolution Foundation, www. resolutionfoundation.org.

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