The Countess of Chester Hospital Whistle-blower Case Study

Kaylie Efstratiou

I. Case Objective & Overview

The following case examines whistle-blowing in the workplace and how it is treated in organizational culture, dealing with the varying ethical perspectives displayed when managerial staff are faced with a whistle-blower. In 2015, an alarming number of infants began to mysteriously pass away in the neonatal ward at the Countess of Chester Hospital. After a few staff members began to realize that one nurse, Lucy Letby, may have been a common denominator in the deaths, a report was made and brought to the attention of the unit manager. When nothing was done after several meetings, some of the staff took their concerns to higher managers. However, the higher-ups remained unphased and complacent. During this time, babies with seemingly good prognoses continued to pass away. It would take more than a year after the initial incidents occurred for Letby to be removed from the neonatal unit - and months after that for hospital executives to contact the police. After her departure, the mysterious deaths ceased.

II. Case Narrative

Adapted from: Judith Moritz, J. C. & M. B. (2023, August 18). *Hospital bosses ignored months of doctors' warnings about Lucy Letby*. BBC News. https://www.bbc.com/news/uk-66120934

The conversation below is between whistle-blower Dr. Breary and an investigative reporter. The two are discussing the unforeseen events that followed Breary's initial report of misconduct in the neonatal unit.

REPORTER: So, you're telling me that - they didn't do anything?

BREARY: I wish that I could say otherwise. I truly thought that with the gravity of the situation, something, anything would be done. But all the executives could think about was the damage a

story like this would do to their reputations, as well as the hospital's. And babies continued to die.

REPORTER: It's just so wrong. What exactly did they say when you brought up these concerns? I can't imagine how they were able to completely skirt addressing this.

BREARY: In their eyes, the end justifies the means. When I initially brought my concerns to my direct unit manager, Ms. Powell, she said that it was unfortunate to have such high rates of death, but any linkage to Lucy was purely coincidental.

REPORTER: That's quite the assumption to make. What did you do after that?

BREARY: I contacted the Director of Nursing and heard nothing back. Then, I requested an urgent meeting with the Medical Director. Three months passed before I heard anything back, and two more babies almost died during that time frame.

REPORTER: And what was that meeting like, when it finally happened?

BREARY: I made myself very clear. Both the nursing and medical directors listened to me passively, and Lucy was allowed to continue working. Months went by, more babies died. I called a hospital executive and demanded Lucy be removed from the unit. She refused, and I asked her point blank if she was taking responsibility for any subsequent deaths. I mean, she was going against the wishes of seven registered pediatricians. She said yes.

REPORTER: And when Ms. Letby was finally removed, was that when the police got involved?

BREARY: No. My colleagues and I were vocal about the need for a third party investigation, but the medical director told us to stop talking about it. He said that "action was being taken". One of the consultants said that in an executive meeting, the head of corporate affairs and legal

services warned police involvement would be a catastrophe for the hospital, that it would turn the neonatal unit into a crime scene.

REPORTER: My god. I've also heard that yourself and some other doctors were made to apologize to Letby?

BREARY: That's right. The CEO told Lucy and her father that she had done nothing wrong. My colleagues and I were told that if we did not apologize to Lucy, there would be consequences. He said we had "crossed a line".

REPORTER: It's horrible to hear that your grave concerns were framed so negatively, and quite frankly astonishing that the executives placed seemingly no value in the opinions of their own physicians.

BREARY: "There was no credibility given to our opinions. And from January 2017, it was intimidating, and bullying to a certain extent. It just all struck me as the opposite of a hospital you'd expect to be working in, where there's a safe culture and people feel confident in speaking out" (Moritz, 2023).

III. Key Concepts

Whistle-Blowing: when a member of an organization reports a perceived ethical wrongdoing to their superior.

Organizational Culture: artifacts, values, and assumptions derived from interactions between members of an organization.

Ethics: the study of 'right conduct'.

Deontological Perspective of Ethics: the ethicality of actions is determined by their adherence to predetermined norms, as opposed to the subsequent consequences.

Teleological Perspective of Ethics: the ethicality of actions is determined based on their consequences.

IV. Theoretical Briefing

Whistle-Blowing occurs when an organizational member suspects or has evidence of unethical, illicit, or illegal behavior being displayed by another organizational member, and reports it to their superior (Richardson 2017). Whistle-blowers most often report major acts of wrongdoing, rather than trivial missteps. These major acts consist primarily of those that could physically or financially harm employees or consumers, breach trust between the company and the public, directly violate the law, or that are carried out by high-ranking organizational members (Richardson 2017). Note that whistle-blowing should be considered a process, rather than an event, as it occurs in stages. The process typically has five stages and involving three distinct actors: the whistle-blower, the wrongdoer, and the target to which the complaint is brought (Near et al. 2008).

The first stage to includes the “triggering event” that sets the rest of the process into motion. Here, the whistle-blower bears witness to the perceived wrongdoing. In the second stage, the whistle-blower is thrust into the decision-making process. They may ask for the advice of their coworkers and engage in a cost-benefit analysis process where they weigh the benefits and drawbacks of sounding the alarm. In the third phase, the individual makes the decision whether or not to blow the whistle. The fourth stage regards the organization’s reaction to the whistle being blown, which can include retaliation or a thorough listening and investigative process. In the fifth stage, the whistle-blower reflects on the action that has or has not been taken by the target (Near et al. 2008).

Retaliation is usually the main deterrence for those who choose not to blow the whistle, as the undesirable actions taken by the target in direct response to the whistle-blowing and can include job termination, threats, ostracism, etc. (Near et al. 2008). For those who do move forward, they must decide which type of channel they would like to report the incident through, either anonymously or publicly. Those who choose to remain anonymous are often worried about the possibility of retaliation, however, including a name often provides the complaint with more

credibility (Near et al. 2008). Most whistle-blowers' reports are internal, but external reports are often made if the complaint is not handled to the individual's satisfaction (Richardson & McGlynn 2011).

Organizational culture refers to the set of artifacts, values, and assumptions that are derived from interactions between members of the organization (Keyton 2011). This is why often organizational communication scholars often note that organizations do not HAVE culture, but rather ARE culture (Smirchich, 1983). Artifacts found in organizations include customs, mission statements, and logos (Schein 1992). They are visible in the everyday organizational setting, though their meaning can require some deciphering. Values constitute organizational ideals regarding what exactly the institution should seek, as well as how its members should behave. They are manifested through the behavior of organizational members through the key characteristics of workplace practices, rituals, and vocabulary. For example, if a manager tells employees that in order to increase sales, there must also be an increase in advertising. The employees might consider this a declaration of their manager's values, and oftentimes may be inclined to take on these values themselves, especially if they are proven to bring success to the originator. This can (but does not always) lead to organizational members developing shared beliefs and values that are often so ingrained and natural to organizational members that they do not discuss it anymore and remain a tacit presence. For example, basic assumptions in a culture can often run so deep that one who does not share these beliefs could be deemed "foreign" or "crazy" (Schein 1992).

Keyton (2011) determined five characteristics of organizational culture: the link to organizational members, as they aid in creating, participating in, and sustaining culture; the dynamic-not-static nature; competing assumptions and values that bring with them subcultures; inevitable emotionality due to the connection between meaning and emotion when discussing artifacts, values, and assumptions; and as operating in the present based on what the culture created in the past has been like. A consensual view of organizational culture is usually achieved when most organizational members have aligned sets of artifacts, beliefs, and

assumptions (Keyton 2017). Keyton also describes how a strong leader can work to further develop this integration through the cycle of generation and propagation that continuously determines artifacts, values, and assumptions. Subcultures are developed when the individual core values of employees differentiate from the status quo, and they begin to propagate their own artifacts, values, and assumptions (Keyton 2017). Poor workplace cultures can arise when company values do not seem to align with their behaviors (May 2012). In an example from the notorious ethical failure of Enron in 2001, Steve May describes how the organizational value of "communication" began to be interpreted negatively, as co-workers were made to evaluate each other, which quickly created an atmosphere of paranoia (2012).

Ethics can be broadly defined as the study of "right conduct" (Lair 2017). Living by an ethical system provides the individual with the direction to live a good life (Cheney 2010). There are two distinct approaches to ethics and its intersection with organizational communication: *descriptive* and *normative* (Lair 2017). The descriptive approach examines the relationship between communicative behaviors and their effects on ethical decision-making. This can be done either by examining the way in which organizational members communicate in order to determine what is or is not ethical, or by entering the situation assuming unethical outcomes, and focusing on the communicative behaviors that produce or justify them. There is an important distinction between the descriptive and normative approach: the former seeks solely to focus on ethical communication in organizations as they are, rather than how they could be, whereas the normative approach, however, seeks to provide judgements on what is deemed ethical or unethical communicative behavior. This can be done in two ways, one of which consists of examining existing cases or types of behavior and applying predetermined ethical standards to them. The second way is done by developing new ethical organizational communication principles or by researching how existing ethical theories impact organizational communication (Lair 2017).

The contest of meanings for the term and the lack of scholarly organizational communication work on the subject leaves *ethics* with a broad definition (Lair 2017). Communication scholars

have noted that we seem to collectively favor speaking in terms of “morality”, rather than “ethics”, due to the compassionate nature of the former and the regulatory connotation of the latter (Cheney 2008). Cheney, for example, emphasizes the importance of studying ethics in his reference to the life of J. Robert Oppenheimer, who became lost after he realized the truly devastating impact his creation of the nuclear bomb would have on the world. He was both unable to join peace movements and to continue working in the scientific community. This grave example offers lessons for how deeply ethics is entangled with our social identities (Cheney 2008).

The **deontological perspective of ethics** determines the ethicality of situations based upon their congruence to predetermined norms rather than consequences (Lair 2017). This perspective can be best summarized in the sentiment which states that “the ends do not justify the means” (Lair 2017). The moral beliefs of Enlightenment thinker Immanuel Kant best exemplify deontological ethics. Kant’s *categorical imperative* states to “Act only according to that maxim whereby you can, at the same time, will that it should become a universal law” (Kant). This means that a person should act in such a fashion that would still afford them satisfaction in a hypothetical world, where these actions were to become universal laws (Lair 2017).

The deontological perspective of ethics can be further exemplified through the examination of codes of ethics and specific duties expected of organizational members (Lair 2017). For example, Lair provides the case in which they are bound to their given duties of protecting patient privacy unless the patient is a threat to themselves or others. This case illustrates that although the deontological approach to ethics seems straightforward in its rules-based ethicality, it does not make ethical decision-making easier. There are many times when ethical duties conflict with themselves, and an organizational member must decipher which choice to make themselves (Lair 2017).

The **teleological perspective of ethics**, on the other hand, is concerned with the consequences of actions (Lair 2017). In this perspective, the outcome of a situation is the

determinant of its ethicality, and that this perspective has long been equated with the notion of achieving the "greatest good" for all. Utilitarian thinkers Jeremy Bentham and John Stuart Mill espoused the values of the teleological perspectives well, offering that "actions are ethical to the degree that they maximize happiness (and minimize unhappiness) for the greatest number of people" (Lair 2017).

As to how the teleological perspective functions in an organizational setting, Lair (2017) provides an example concerning corporate social responsibility. In 2015, Wal-Mart and other stores stopped carrying Confederate flags in response to the public outcry of one being raised during the wake of a mass murder at a black church in South Carolina. He reasons that Wal-Mart did not cease the sale of the flags due to their dedicated opposition to the flag on principle, but instead due to the fear of negative public consequences they might have suffered had they not. In doing so, Wal-Mart was effectively trying to appease the greatest amount of people while displeasing the least, perfectly encapsulating the teleological perspective of ethics (Lair 2017).

V. Questions for Discussion

1. Based on the discussion between Dr. Breary and the reporter about the initial handling of the case of nurse Lucy Letby, where do you see examples of the different ethical perspectives at play?
2. What can you infer about the reasoning behind each of these specific ethical perspectives?
3. What were some of the cultural artifacts, values, or assumptions that could have existed for different actors involved with the situation at Countess of Chester Hospital during this time?
4. Describe the organizational culture at Countess of Chester Hospital during this time.
5. At what points during his retelling of the scandal is Dr. Breary moving through the different steps involved in the whistle-blowing process? Which steps were they?

6. Who were the three actors involved in the whistle-blowing process? What were each of their roles?
7. What could be some of the possible reasons had Dr. Breary ultimately decided not to blow the whistle?
8. Where can you see an example of retaliation taking place in the conversation between Dr. Breary and the reporter

Works Cited

Cheney, G. (2008). Encountering the ethics of engaged scholarship. *Journal of Applied Communication Research*, *36*(3), 281–288. https://doi.org/10.1080/00909880802172293

Cheney, G. (2010). *Just a job?: Communication, ethics, and professional life*. Oxford University Press.

Judith Moritz, J. C. & M. B. (2023, August 18). *Hospital bosses ignored months of doctors' warnings about Lucy Letby*. BBC News. https://www.bbc.com/news/uk-66120934

Kant, I., Denis, L., & Gregor, M. J. (2017). *The metaphysics of morals*. Cambridge University Press.

Keyton, J. (2011). *Communication and organizational culture: A key to understanding work experiences*. SAGE.

Keyton, J. (2017). Culture, organizational. *The International Encyclopedia of Organizational Communication*, 1–20. https://doi.org/10.1002/9781118955567.wbieoc155

Lair, D. J. (2017). Ethics. *The International Encyclopedia of Organizational Communication*, 1–12. https://doi.org/10.1002/9781118955567.wbieoc075

May, S. (2013). *Case studies in organizational communication: Ethical perspectives and practices*. SAGE Publications.

Miceli, M. P., Near, J. P., & Dworkin, T. M. (2008). *Whistle-Blowing in Organizations*. https://doi.org/10.4324/9780203809495

Richardson, B. K. (2017). Whistle-Blowing. *The International Encyclopedia of Organizational Communication*, 1–10. https://doi.org/10.1002/9781118955567.wbieoc218

Richardson, B. K., & McGlynn, J. (2010). Rabid fans, death threats, and dysfunctional stakeholders: The influence of organizational and industry contexts on whistle-blowing cases. *Management Communication Quarterly*, *25*(1), 121–150. https://doi.org/10.1177/0893318910380344

Schein, E. H. (1992). *Organizational culture and leadership: 2nd ed*. Jossey-Bass

Smircich, L. (1983). Concepts of culture and organizational analysis. *Administrative Science Quarterly*, *28*(3), 339. https://doi.org/10.2307/2392246