Organisational factors that prevent nurses from whistleblowing: a review of the literature.

Abstract

This paper is a literature review submitted as part of the academic requirements of the BSc Honours Degree course I am currently pursuing. The topic I chose to review was whistleblowing in nursing, more specifically why nurses do not whistleblow. Because of cases such as the Leas cross Inquiry and the Rostrevor case coming to the forefront of Irish media in recent times, interest for this literature review stems from the author’s belief that nurses must protect patients from harm through advocacy, reporting and if necessary, whistleblowing.

This research seeks to answer the research question: ‘How do organisational factors prevent nurses from whistleblowing?’ A manual review of the literature was carried out with the intention of highlighting the organisational factors that exist which prevent nurses from whistleblowing. A computer search was conducted of databases including: CINAHL, Science Direct, Trip database and the Cochrane Library. The following keywords were used: whistleblowing, organisational factors, organisational culture, dilemma, raising concerns, barriers and patient safety. Initial search limitations included: literature no more than five years old and Irish and UK journals only. However, this resulted in too little research on the topic and the search was expanded to include non-Irish/UK journals as well as one article dating back to 2005. In-depth analysis of the literature resulted in the identification of twelve articles relevant to the review. The major theme that emerged was ‘organisational culture’.

The definition of whistleblowing is varied throughout the literature; however the most cited being that whistleblowing is the act of highlighting and taking a stand against organisational wrongdoing. The overall image that emerges from the literature is negative: closed culture, poor response to the raising of concerns, silence and fear. Findings from this research suggest that organizational culture plays a major role in whether or not nurses will raise concerns. Whistleblowing still appears to be somewhat of a taboo subject. Patient safety is paramount in healthcare and nurses need to put patients’ needs before their own. It is evident form the literature, that a sense that ‘nothing would be done’ in relation to the raising of their concerns was the most commonly cited reason as to why nurses remained silent about wrongdoings in their workplace. However, such negative perceptions appear to stem from the organisational culture in which they work. The literature suggests that it is the leaders in such organisational climates that set the standards for what is accepted as common practice.

However, nurses have a duty of care to their patients and cannot turn a blind eye to situations that raise serious concerns. Silence is a cancer which eats away at organisations. Organisational culture plays a major part in the decisions of nurses who contemplate whistleblowing. In reality, facilitating factors, appropriate organisational infrastructures and proper support systems need to be put in place in order to encourage and support whistleblowers. There is a need for authentic change within organisational systems to allow nurses raise concerns and above all the absolute need for disincentives to reporting to be removed.
The aim of this review is to explore the organisational factors that prevent nurses from whistle-blowing. Interest for this literature review stems from the author’s belief that nurses must protect patients from harm (An Bord Altranais (ABA) 2000a) through advocacy, reporting and if necessary, whistle-blowing. The Health Information and Quality Authority (HIQA) was set up as a response to the Leas Cross Inquiry, and although it acts as an independent body, the Rostrevor case still occurred even though HIQA had previously inspected it (Donnellan 2011).

Donnellan (2011) highlighted that such incidents may continue to occur unless more people become whistleblowers. Therefore, exploration of how organisational factors prevent nurses from whistleblowing is essential due to the complex and challenging arena that nurses currently work in and the need to protect patients’ safety. ABA (2000a) demands that all nurses must give patients the best quality of care possible and that any situation that jeopardises patient safety must be brought to the attention of relevant persons or authorities. This puts an onus and a professional obligation on nurses to report, however as suggested by Attree (2007), despite these requirements the normal response is under-reporting. Also, whistleblowers are often labelled negatively which inhibits many from doing so (Dooley and McCarthy 2005).

ABA (2000b) states that nurses must act as patient advocates and Lachman (2008a) highlights that whistle-blowing is an act of advocacy, carried out with the intention of protecting someone from likely harm. The guidance from An Bord Altranais is quite clear with regard to the nurse’s responsibility in such a situation, however not all nurses choose to blow the whistle on poor practice or situations where patient safety is jeopardised. Whilst no Irish statistics could be located on whistleblowing, an English survey was sourced. Waters (2008),
in her survey of 752 nurses, found that in the previous three years: 68% had encountered patient safety issues which caused them serious concern, however only 87% of that 68% reported their concerns to their manager. In response to their raised concerns, only 29% of managers addressed and resolved these issues, with 47% of the nurses reporting that the matter had been handled poorly or not handled at all. Alarmingly, 23% of the nurses reported that their identified concerns eventually caused the patients harm.

The definition of whistleblowing is varied throughout the literature; however the most cited is that whistleblowing is the act of highlighting and taking a stand against organisational wrongdoing (Firtko and Jackson 2005, Calcraft 2007, Lachman 2008b, Somers and Casal 2011). Also, Ray (2006) states that whistleblowing can be the reporting of poor practices to both internal and external organisations. The nurse who must decide whether or not to blow the whistle is faced with an ethical dilemma and the act may also involve repercussions for all involved due to the secretive and stigmatized nature of it (Jackson et al. 2010a).

This research seeks to answer the research question: ‘How do organisational factors prevent nurses from whistleblowing?’ A review of the literature was carried out with the intention of highlighting the organisational factors that exist which prevent nurses from whistle-blowing. A manual literature review was carried out and a computer search was conducted of databases including: CINAHL, Science Direct, Trip database and the Cochrane Library. The following keywords were used: whistle-blowing, organisational factors, organisational culture, dilemma, raising concerns, barriers and patient safety. Initial search limitations included: literature no more than five years old and Irish and UK journals only. However, this resulted in too little research on the topic and the search was expanded to include non-Irish/UK journals as well as one article dating back to 2005. In-depth analysis of the literature resulted in the identification
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Many disincentives to reporting and whistle-blowing have been highlighted throughout the literature. The culture of organisations emerged as a major theme, whereby nurses viewed the organisational culture as a disincentive to reporting, which in turn lead to whistle-blowing (Firtko and Jackson 2005, Ray 2006, Attree 2007, Calcraft 2007, Rolland 2007, Lachman 2008a, Lachman 2008b, Hill 2010, Jackson et al. 2010a, Jackson et al. 2010b, Somers and Casal 2011).

In their Australian qualitative study, Jackson et al. (2010a) examined the experiences of eleven nurse whistleblowers and found that although the nurses raised issues within their organisations, they felt very little was done in response to their concerns being raised and so they felt that the media had to be involved in order to effect change. The whistleblowers here, suggested that a culture of silence and fear was conspired and created by the organisations. Data analysis is essential in identifying the believability of the findings and involves the changing of raw data into themes and categories (Ryan et al. 2007), and this was clear within this piece of research. Data collection from the eleven nurses was obtained using semi-structured in-depth interviews. The findings from this study highlight the need for healthcare organisations to provide opportunities and a safe environment for nurses to raise concerns and that they must in return respond to their concerns appropriately.

Attree (2007) and Calcraft (2007) both highlighted how the perception of a closed culture within an organisation acted as a disincentive to whistle-blowing. This lack of openness within the organisation can lead to staff institutionalisation (Calcraft 2007) and a sense that any raising of concerns would be viewed in a negative way (Attree 2007). In addition to this,
Calcraft (2007) proposed that such closed cultures that are made up of strong relationships, can lead to staff questioning what acceptable practice standards are which in turn leads to a lack of challenging about and change of poor practice.

Attree (2007) carried out a grounded theory study of the factors that influenced 142 nurses’ decisions to raise their concerns about practice standards within three English Acute NHS Trusts. In this study, the nurse whistleblowers described the organisational culture in which they worked as closed, secretive and of a blaming nature. As a direct result of this, the nurses lacked the confidence to report within their organisational systems, as they perceived that little or nothing would be done in response to their reporting. This was a well conducted study as evidenced through the research design (Parahoo 2006). The results of this study are valid and very relevant to contemporary nursing, as she highlighted that without real changes within organisational systems that nurses will continue to not report concerns. Her findings highlight the need for organisations to adopt a culture where nurses feel safe to report concerns and that such systems should be reviewed.

Lachman (2008a) suggests that whistle-blowing is the result of an organisational failure to address the ethical accountability issues surrounding patient safety. She concluded that whistleblowing is justified if positive changes occur in relation to misconduct, patient safety or the ethical mind-set of the organisation. Similarly, Ray (2006) and Hill (2010) identified whistleblowing as an ethical failure of organisations. The significance of these articles is the relevance of the findings that organisations need to adopt a culture of ethics that alleviates the need for whistle-blowing and the need for organisations to be able to deal with issues raised. Calcraf (2007) also highlighted that whistleblowing is not an easy fate for the individual or the employer. Additionally, Ray (2006) identified that whistleblowing is not something that is
done lightly, but that all other avenues must be exhausted before making the final decision to blow the whistle. Her research concluded with the need for more stringent ethical frameworks to be introduced into organisations in order to minimise the need for nurses to whistle-blow externally.

However, one may argue that this would only work if nurses felt that facilitating factors existed within the organisation. The nurse whistleblowers in Attree’s (2007) study described what they would have perceived as ideal facilitating factors to whistleblowing, which included: a sense of trust and confidence that the organisations would respond to their concerns, an open culture, where raising concerns would be seen as a duty and that potential incident reporting would be dealt with positively and constructively. Calcraft (2007) also identified facilitating factors including: the need to build cultures within organisations that are both positive and open as well as the need to be supportive to staff who do blow the whistle.

In her qualitative research, Calcraft (2007) explored the dilemmas associated with whistle-blowing in social care settings, of incidents involving the abuse of people with learning disabilities. This article was included due to its applicability to the care of all older persons in all care settings (Calcraft 2007). Her research identified that organisational cultures that allow poor practice to be tolerated may be worsened again by managers who do not deal with raised concerns. The relevance of her findings are that she adds that support must be given to whistleblowers and that un-supporting organisational cultures must be explored in further depth and also that barriers to whistleblowing should be investigated if they are to be made known and removed.
Firtko and Jackson (2005) highlighted how raising concerns within organisations is perceived as undesirable and an act that should be avoided. However, they go on to argue convincingly that such behaviour is totally acceptable and even desirable. They highlight that mistrust is a serious issue related to organisational culture and that this is a result of the hierarchical structures that are inherent in healthcare organisations. Their research suggests the need for sufficient internal structures within organisations which would allow for concerns to be addressed internally and that such structures would in turn reduce the incidences of external whistleblowing. They also highlight that nurses need to tackle the organisational culture which results in nurses turning a blind eye to poor practices. These findings are relevant even though it is a discussion paper as opposed to a study of the lived experiences of nurse whistleblowers.

Similarly, the findings of Jackson et al. (2010b), suggest the need for organisations to adopt a positive and safe climate where nurses feel that they can raise concerns. Their study stipulated and affirmed the obligation that all healthcare professionals have to promote change of organisational culture. Although their study focused on the impact whistleblowing has on workplace relationships, it has highlighted that the organisational problems could even involve managers who partake in bullying of the whistleblower. Similarly, Hill (2010) highlighted how the ways in which managers and employers discouraged the involvement of staff in open and honest discussions acted as a deterrent for the reporting of poor practices. Hill (2010) also identified that whistleblowing is the result of failed organisational ethics. However, her research highlights that nurses should speak out when poor practice is witnessed even if it does put their jobs at risk i.e. they should make patient safety a priority over their pay-checks. Rolland (2009) identified how individuals are often blamed for the failure of organisational ethics, however as he rightly points out, such failures are a result of
the ethical climate created by the organisations. His research indicates that whistleblowing occurs as a result of a failure in the ethics of the leaders of an organisation, where they fail to address and resolve the issues raised by staff.

Somers and Casal (2011), in their quantitative research, sought to identify whether the type of wrongdoing observed impacted on whether or not someone would whistleblow, and the findings showed that it did. Their study identified that a sense that nothing would be done in response to reporting was the most common reason given for not reporting, these results have a statistical significance with a p value of <.001 (Parahoo 2006). It must be noted that although Somers and Casal (2011) are of management backgrounds and not nursing, their study and results are very relevant to the organisational culture within nursing. The relevance of these findings to the organisational culture within nursing is that nurses, who perceive that nothing will be done in response to the reporting of wrongdoing, are far less likely to report.

In contrast to the international studies already outlined, Skivenes and Trygstad (2010) carried out an extensive study on whistleblowing in Norway and found very different results to its international counterparts. Their study which was peer reviewed and blind peer reviewed, showed that whistle-blowing is viewed positively in Norway. This article was included as it highlights how facilitating factors enable nurses to whistle-blow. The findings, which are in stark contrast to the English survey carried out by Waters (2008), revealed that 68% of Norwegian nurses who witnessed poor practice reported it and 83% of these, found that their reporting was received positively and resulted in improvements in relation to their raised concern. The findings of their study are very relevant as they highlight how proper organisational structures especially in the area of communication may facilitate whistleblowing.
In conclusion, whistleblowing still appears to be somewhat of a taboo subject. Patient safety is paramount in healthcare and nurses need to put patients’ needs before their own. It is evident from the literature, that a sense that ‘nothing would be done’ in relation to the raising of their concerns was the most commonly cited reason as to why nurses remained silent about wrongdoings in their workplace. However, such negative perceptions appear to stem from the organisational culture in which they work. The literature suggests that it is the leaders in such organisational climates that set the standards for what is accepted as common practice.

This aside however, nurses have a duty of care to their patients and cannot turn a blind eye to situations that raise serious concerns. As Rolland (2009) described it, silence is a cancer which eats away at organisations. Organisational culture plays a major part in the decisions of nurses who contemplate whistleblowing. Facilitating and non-facilitating factors were identified from the literature. In reality, facilitating factors, appropriate organisational infrastructures and proper support systems need to be put in place in order to encourage and support whistleblowers; and Attree (2007) stipulated the need for authentic change within organisational systems which allow nurses to raise concerns and above all the absolute need for disincentives to reporting to be removed.

The Norwegian study was the only study that identified nurses who felt they could blow the whistle without fears and where their concerns were addressed in the majority of cases. Sadly however, as evidenced throughout the literature, this is not the case in its international counterparts. Many organisations still fail to address and resolve the concerns raised by individuals which in turn lead to them having to whistle-blow. Even though nurses blow the whistle to protect patient safety, the act is still viewed in a negative way and also as an act that is stigmatised (Calcraft 2007).
The biggest challenge in improving patient safety is often to change ward culture (Sandars and Cook 2007) and the Department of Health & Children (2008) suggests that ‘open disclosure’ should be protected legally. The act of whistleblowing requires the person to be morally courageous and that whistleblowers are generally perceived as courageous individuals who speak out against the poor practices of an organisation (Lachman 2008a) and thankfully there are some nurses out there that still carry out the act regardless of the negativity and personal risks that they may subsequently suffer (Firtko and Jackson 2005, Ray 2006). However, as whistleblowing remains for the most part a stigmatised phenomenon with limited research available due to the sensitivity of it, more research is required in relation to it, in particular research on how it may be accepted into the culture of organisations. Finally, as Rolland (2009) identified, healthcare organisations need to increase standards to a level that patients deserve.
References


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