



The Role of Employee Whistleblowing and Raising Concerns in an Organizational Learning Culture – Elusive and Laudable?

Comment on “Cultures of Silence and Cultures of Voice: The Role of Whistleblowing in Healthcare Organisations”

Aled Jones*

Article History:

Received: 15 September 2015
Accepted: 2 October 2015
ePublished: 5 October 2015

*Correspondence to:

Aled Jones
Email: JonesA97@cardiff.ac.uk

Abstract

It is inevitable that healthcare workers throughout their careers will witness actual or potential threats to patient safety in the course of their work. Some of these threats will result in serious harm occurring to others, whilst at other times such threats will result in minimal harm, or a ‘near miss’ where harm is avoided at the last minute. Despite organizations encouraging employees to ‘speak up’ about such threats, healthcare systems globally struggle to engage their staff to do so. Even when staff do raise concerns they are often ignored by those with a responsibility to listen and act. Learning how to create the conditions where employees continuously raise and respond to concerns is essential in creating a continuous and responsive learning culture that cherishes keeping patients and employees safe. Workplace culture is a real barrier to the creation of such a learning system but examples in healthcare exist from which we can learn.

Keywords: Whistleblowing, Workplace Culture, Patient Safety, Organizational Learning

Copyright: © 2015 by Kerman University of Medical Sciences

Citation: Jones A. The role of employee whistleblowing and raising concerns in an organizational learning culture – elusive and laudable? Comment on “Cultures of silence and cultures of voice: the role of whistleblowing in healthcare organisations.” *Int J Health Policy Manag.* 2015;4(x):x–x. doi:10.15171/ijhpm.2015.182

Mannion and Davies provide a timely overview of the important role that employee whistleblowing can play in assuring patient safety and generally enhancing the quality of care within healthcare organisations.¹ They remind us that although whistleblowing can make an important contribution to patient safety² and saving lives, the act of whistleblowing and the fate of whistleblowers has a somewhat tortured history in healthcare organisations internationally.³ For example, the fate of whistleblowers is characteristically bleak, in that if they have not already decided to resign they can often be dismissed from their employment.⁴ There is also the prospect of those whistleblowers who remain in their jobs being blacklisted or ostracized by work colleagues, leading to personal suffering with marital breakdown, long-lasting health, financial, and personal problems being documented.^{5,6}

As the title of Mannion and Davies’s piece makes clear and others have empirically demonstrated,⁷ the effect of workplace culture emerges as a key variable in determining whether employees raise concerns or stay silent when confronted with unacceptable standards of practice. In addition, workplace cultures are also identified as a key variable in determining whether employees’ concerns are listened to and acted upon, or disregarded and ignored, when disclosed to others.⁸

However, a seldom considered yet important corollary of an anti-whistleblowing workplace culture is the effect that enforced silence and passivity in the face of apparent

wrongdoing has on individual staff members. Anecdotal evidence is supported by research which suggests that enforced silence results in similar levels of physical and emotional distress that whistleblowers experience,⁹ although more research is badly needed.

Before continuing, the definition of whistleblowing used in this commentary is slightly broader than the one that Mannion and Davies used (albeit loosely, by their own admission), which positioned whistleblowing as a ‘disclosure to a person or public body, outside normal channels and management structures, of information concerning unsafe, unethical or illegal practices.’ Instead, I would suggest that a definition of whistleblowing does not need to be confined to disclosures that occur ‘outside normal channels and management structures,’ especially as defining the parameters of ‘outside normal channels’ may be fraught with difficulty. So, the definition used here is simply that a whistleblower is a person who raises concern about a perceived wrongdoing.² As a result the terms whistleblower (and its derivatives) are used interchangeably with the term raising concerns.

Whistleblowing – Laudable if Elusive?

Mannion and Davies’s article ends by raising the possibility that the creation of the right organizational culture, where employee voices are openly aired and whistleblowing leads to improved patient safety, is ‘a laudable if elusive goal’ (p.3) to aspire to. The following section picks up where the authors

left off by considering this statement further.

There is little doubt that whistleblowing is a laudable endeavor, although interestingly there is a dearth of coverage in the literature of cases that detail how, or where whistleblowing leads to improved patient safety. Therefore, there is only indirect evidence that supports the argument that a whistleblowing culture is laudable, consisting mostly of retrospective analyses of numerous cases where major safety failings occur due to whistleblowers being ignored. Such retrospective analyses have led to attempts to normalize whistleblowing as one of numerous approaches to improving patient safety. However, there remains considerable work to be done to ensure and demonstrate that whistleblowing informs safety prospectively, rather than retrospectively and belatedly learning from whistleblowers once harm has already occurred to patients and employees.

Prospective Learning From Whistleblowing – Is It Elusive?

So is there any tangible, solid evidence for the existence of prospective systems of organizational learning from employees' concerns, or are such systems elusive? Overall such systems of learning, especially in the United Kingdom, have traditionally been elusive. For example, appeals for the UK National Health Service (NHS) to prospectively learn from whistleblowers have largely gone unheard over the last 40 years since the first inquiry into wrongdoing at a NHS hospital.¹⁰ However, work presently being undertaken in response to recent failures to learn from employee concerns suggests that change may be imminent.¹¹

Concrete evidence of organizational environments in healthcare, which prospectively learn from staff concerns can be seen outside of the United Kingdom. For example, the Patient Safety Alert (PSA) system designed by Virginia Mason Medical Center (VMMC) in Seattle, WA, USA has transformed the working environment. Although the PSA system initially focused only on actual lapses or near misses in safety and medical error, a PSA is now intended to capture all events involving the safety and well-being of a patient such as medication errors and grade 3 to 4 pressure ulcers, elevators not working properly and disruptive behaviours of staff and patients.

Prior to the introduction of the PSA Virginia Mason employees were very reluctant to raise concerns as VMMC was not an organization that was attuned to learning from their staff. Safety concerns that were reported would largely be filed away and forgotten, rather than used to trigger improvements in safety. Moreover, staff believed that raising safety concerns would result in punishment or loss of employment.

In response to this senior managers and executives designed the PSA system in an attempt to change the dysfunctional culture related to raising and responding to concerns in VMMC. For example, instead of criticizing or silencing employees who raise concerns managers and executives were trained to offer support and resources to fix issues that concerned staff. In addition, VMMC openly share with staff information about how the PSA system has led to improved safety outcomes. They also share with staff examples of how, rather than victimizing those who raise concerns, employees who raise concerns are welcomed and valued. As a result of these and other changes between March 2002 and January

2014 staff raised concerns a total of 43615 times. This has grown from around 10 or so reports a year in the period 2002-2004, to 850 reports a month in January 2014.^{12,13} The PSA system appears to have succeeded in creating a system for raising and responding to concerns that is fully integrated in “real time” with related systems that coordinate patient safety and quality improvement, thus avoiding being a ‘bolt-on’ or separate system that Mannion and Davies caution against and often led to retrospective rather than real time or prospective learning.

Another system that appears to have integrated whistleblowing successfully into the workplace is the Norwegian public services. In Norway, 76% of health and education sector employees raise concerns when they observe wrongdoing in the workplace, a very high proportion compared with whistleblowing in the United States and United Kingdom.¹⁴

The reasons for such a high proportion of staff reporting concerns is better understood it is taken into account that 83% of Norwegian employees received positive reactions when they raised concerns and 64% reported seeing improvements in their workplace after concerns were raised. A point for further consideration which alas is beyond the scope of this piece on organizational culture (and expertise of the author), but nonetheless worthy of more attention, is the effects of differences in whistleblowing and employment legislation on reporting and responding behaviours. For example, it has been reported that in the context of whistleblowing dismissal protection of individual workers in Norway is strong compared with the United States and United Kingdom.¹⁴

Warning – Past Success Is no Guarantee of Future Success!

The examples from the United States and Norway suggest that workplace environments, which value employee whistleblowing and voice, are both laudable and not elusive. However, what is also interesting in both of these examples is an apparent (and healthy) realization that their past or current success in encouraging staff to raise and respond to concerns provides few guarantees of future success. As a result of this realization both examples demonstrate a preoccupation with constantly monitoring their systems of reporting and responding to concerns and ensuring that concerns lead to learning and system improvement. This preoccupation demonstrates a commitment to a detailed understanding of not only what concerns their staff, but also the process that staff use to raise their concerns.

The approaches adopted in Norway and the United States are the antithesis of the ‘build it and they will come’ model of monitoring employees' safety concerns and reports, which sees organizations operate under a misunderstanding that (a) it is only the number of concerns that are raised that is important, (b) reporting of concerns is the endpoint of learning, rather than the beginning of learning, and (c) if a system for reporting of concerns is provided then staff will use and continue to use the system. Similar points to these are made in Macrae's recent critique¹⁵ which focuses specifically on patient safety incident reporting. This excellent overview also reflects issues that have plagued whistleblowing or raising concerns systems in the past and offer a frank reminder at times of potential change in whistleblowing across the UK NHS that merely providing staff with a system of whistleblowing and

reporting concerns is the easy bit. Building and maintaining a pro-whistleblowing workplace culture cannot be achieved, therefore, by merely bolting-on a reporting system that is left to run unattended and unmonitored.

Ethical issues

Not applicable.

Competing interests

Author declares that he has no competing interests.

Author's contribution

AJ is the single author of the manuscript.

References

- Mannion R, Davies HT. Cultures of silence and cultures of voice: the role of whistleblowing in healthcare organisations. *Int J Health Policy Manag.* 2015;4(8):503-505. doi:10.15171/ijhpm.2015.120
- Bolsin S, Pal R, Wilmshurst P, Pena M. Whistleblowing and patient safety: the patient's or the profession's interests at stake? *J R Soc Med.* 2011;104(7):278-282. doi:10.1258/jrsm.2011.110034
- Kelly D, Jones A. When care is needed: the role of whistleblowing in promoting best standards from an individual and organizational perspective. *Qual Ageing Older Adults.* 2013;14(3):180-191. doi:10.1108/qaoa-05-2013-0010
- Gallagher A. Whistleblowing: what influences nurses' decisions on whether to report poor practice. *Nurs Times.* 2010;106(4):22-25.
- Perry N. Indecent exposures: theorizing whistleblowing. *Organ Stud.* 1998;19(2):235-257. doi:10.1177/017084069801900204
- Jackson D, Peters K, Andrew S, et al. Understanding whistleblowing: qualitative insights from nurse whistleblowers. *J Adv Nurs.* 2010;66(10):2194-2201. doi:10.1111/j.1365-2648.2010.05365.x
- Jones A, Kelly D. Whistle-blowing and workplace culture in older peoples' care: qualitative insights from the healthcare and social care workforce. *Sociol Health Illn.* 2014;36(7):986-1002. doi:10.1111/1467-9566.12137
- Vandekerckhove W, Brown A, Tsahuridu E. Managerial responsiveness to whistleblowing: Expanding the research horizon. In: Brown AJ, Lewis D, Moberly R, Vandekerckhove W, eds. *International Handbook of Whistleblowing Research.* Cheltenham: Edward Elgar Publishing; 2014:298-327.
- McDonald S, Ahern K. Whistle-blowing: effective and ineffective coping responses. *Nurs Forum (Auckl).* 1999;34(4):5-13. doi:10.1111/j.1744-6198.1999.tb01165.x
- Jones A, Kelly D. Deafening silence? Time to reconsider whether organisations are silent or deaf when things go wrong. *BMJ Qual Saf.* 2014;23(9):709-713. doi:10.1136/bmjqs-2013-002718
- Francis R. Freedom to speak up. An independent review into creating an open and honest reporting culture in the NHS. http://socialwelfare.bl.uk/subject-areas/services-activity/health-services/freedomtospeakupreview/171114F2SU_web.pdf. Published 2015.
- Patterson S. Pursuit of the perfect patient experience: how Virginia Mason became a high performing healthcare system. <http://www.kingsfund.org.uk/sites/files/kf/media/Sarah%20Patterson%20-%20Pursuit%20of%20the%20perfect%20patient%20experience.pdf>. Published 2014.
- Kenney C. *Transforming health care. Virginia Mason Medical Center's pursuit of the perfect patient experience.* Boca Raton, FL, US: CRC Press; 2011.
- Skivenes M, Trygstad SC. When whistle-blowing works: the Norwegian case. *Hum Relat.* 2010;63(7):1071-1097. doi:10.1177/0018726709353954
- Macrae C. The problem with incident reporting. *BMJ Qual Saf.* 2015. doi:10.1136/bmjqs-2015-004405