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Deafening silence? Time to reconsider whether organisations are silent or deaf when things go wrong

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ABSTRACT

Several public inquiries into healthcare failings in the UK have noted that employees of failing organizations attempt to raise concerns about shortcomings in care, often over a prolonged period of time, only for those concerns to be ignored. However, healthcare literature has largely focused on how organizations and their employees are silent in the face of such failings, positioning employees as daring not to speak in response to serious workplace problems or issues. We argue that only focussing on organizational silence is a critical mistake which misrepresents actual events and overly-simplifies the complexities of workplace culture. The disregard shown by academics, practitioners and policy makers to employee voice strategies, which do not amount to whistle-blowing, but equally cannot either be defined as "silence", results in signals being ignored that can be effective in preventing and ending wrongdoing by others. In addition to understanding silence we suggest therefore that better understanding of why organizations are deaf to, or disregard, employee concerns are needed. We propose that a virtuous cycle is possible, whereby the introduction of systems that result in better listening and valuing of employee concerns reinforces a culture of speaking up and, in turn, organizational learning. Similarly, organizations that disregard employees concerns are destined not to learn, ultimately falling silent and failing.

INTRODUCTION

When news breaks of devastating failings in healthcare, a common response is to question why staff did not raise their concerns when witnessing questionable standards of care. In 2009, the then incumbent UK health secretary Alan Johnson, commenting on failings at Mid Staffordshire National Health Service (NHS) Foundation Trust, a hospital in England, said he was mystified that nurses, doctors and the public failed to blow the whistle on poor practice.[1] Mr Johnson's incredulity stemmed from the fact that, at the time, there was no evidence of staff formally voicing their concerns to external agencies or regulators. However, subsequent independent and public inquiries chaired by Sir Robert Francis found that a number of staff were not silent in the face of mistreatment of patients (and staff), but instead raised their concerns about standards of poor care and were ignored.

For example, the public inquiry heard that patient safety incident reports submitted by staff described dangerously low levels of staffing on 940 occasions to the National Patient Safety Agency between 2005 and 2010.[2] Staff nurse Helene Donnelly spoke out in October 2007 and was told by fellow nurses to 'watch her back', while a junior doctor described the accident and emergency department as an absolute disaster area that was 'immune to the sound of pain'. He repeatedly raised issues with the trust's management before documenting his concerns with his postgraduate Dean, who took no action. A consultant gastroenterologist raised concerns within the trust over many years but was ignored by managers and temporarily suspended as a result, the inquiry heard.[3]

Inquiry counsel Tom Baker described the repeated raising and subsequent disregard of concerns in Mid Staffordshire as 'a cry from staff who appear to be being ignored'.[4] Indeed, numerous inquiries into suboptimal treatment of patients in the UK dating back to the 1960s have concluded that failing healthcare organisations are often characterised by staff who report their concerns about patient care to colleagues. One such example can be seen in The Howe Report,[5] the first public inquiry into malpractice in a NHS hospital, which reports the 'indifference on the part of the Chief Male Nurse to complaints that were made to him' (p.2)

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by staff shocked at the mistreatment of patients with learning disabilities.

Despite such a profound and long history of staff attempting to raise concerns about suboptimal care, only to be ignored, healthcare researchers have focused on two relatively narrow but related concepts, namely, whistle-blowing and organisational silence. In this article, we argue that solely focusing on whistle-blowing or silence misrepresents actual events and often overly-simplifies an inherently complex set of actions and interactions. One effect of this oversimplification is a failure to see, or hear, that staff do routinely raise their concerns in a multitude of different ways. We suggest that an alternative and more nuanced and contextualised understanding of the ways in which healthcare employees might respond when confronted with suboptimal care is needed, both by researchers who seek to better understand reporting behaviours and policy makers and organisations who wish to respond in a more timely and efficient manner to concerns raised by staff.

WHISTLE-BLOWING AND ORGANISATIONAL SILENCE

A widely used definition[6] describes whistle-blowing as a 'Disclosure by organization members (former or current) of illegal, immoral or illegitimate practices under the control of their employers, to persons or organizations that may be able to effect action' (p.689). The term is sometimes used to describe staff reporting concerns to external agencies such as regulators or the police, while at other times it encompasses reporting of concerns internally within an organisation to colleagues such as managers or supervisors. The term whistle-blowing is increasingly being used synonymously with the less contentious term 'raising concerns', as seen in the following definition: 'a whistle-blower is defined as a person who raises concern about a wrongdoing' (p.278).[7]

On the surface at least, whistle-blowing would appear to be the most rational and correct action for employees to take when confronted with poor standards of care. In reality, however, whistle-blowing is often perceived by colleagues within the workplace as an act of betrayal. As a result of this perception, the fate of whistle-blowers is often bleak. For example, the personal and professional costs to whistle-blowers are high in that if they have not already decided to resign from their employment following victimisation by colleagues they are often dismissed. There is also the prospect of those remaining in their jobs having their career prospects curtailed and being ostracised by colleagues, all of which can lead to personal suffering, with marital breakdown, long-lasting health, financial and personal problems having also been documented.[8] It is unsurprising therefore that Dame Janet Smith, who chaired the Shipman Inquiry, reported her wish to avoid the expression 'whistle-blowing', but found this to be difficult due to its ubiquity, particularly within organisations' policy documents.[9] Despite its negative associations, the word has strong social significance and cannot be erased easily.

Our recent research suggests that the problems associated with being identified as a whistle-blower meant that staff avoided formal whistle-blowing routes such as reporting to external regulators and instead raised concerns in other more informal and less explicit ways.[10] These informal routes included instances where staff:

A. Verbally raised their concerns directly with a perpetrator of mistreatment, or indirectly via the use of humour or sarcasm.
B. Wrote a letter, email or raised concerns verbally with line-managers or supervisors.
C. Referred their concerns through an anonymous reporting system within the employing organisation.

For these reasons, the act of raising concerns was often an activity that was concealed from all but a few individuals who work together and understand each other's working lives. As a result, concerns were raised in ways that may not be identifiable as whistle-blowing activity. One result of such activity being hidden is that staff within organisations such as Mid Staffordshire NHS Trust may appear to be silent to the outside world, when in fact they are not.

The term Organisational Silence was initially put forward[11] to describe a situation where 'most employees know the truth about certain issues and problems within the organisation yet dare not speak that truth to their superiors' (p.706). The term has found its way from management studies into the healthcare literature and been defined as 'The collective-level phenomenon of doing or saying very little in response to significant problems or issues (p.1539)'.[12]

However, we would now question, in light of inquiries and studies which suggest that staff often report concerns within organisations, whether the notion of organisational silence is adequate—and whether the description of organisational silence as 'the dominant choice within many organisations' (p.707)[11] is accurate. It is also apparent that the phrase 'Organisational Silence' is often deployed unhelpfully as an umbrella term which glosses over a myriad of staff behaviours and responses to wrongdoing in the workplace, while the overarching emphasis on staff silence relentlessly but falsely positions employees as completely lacking in voice.

A problematic consequence of viewing staff as either whistle-blowers or silent witnesses can be seen in much healthcare research. For example, a recent study[13] which surveyed staff experiences of and responses to whistle-blowing stated that 'whistle-blowers' are faced with two options: 'they can report the misconduct or remain silent' (p.167). Such a narrow, binary conceptualisation of the responses of nurses is problematic. Indeed, despite finding that 'a total of 79% (n=38) of

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the nurses who observed "bad clinical practice" reported it' (p.170), the authors concluded that a 'culture of silence' (p.177) exists in Irish hospitals.

The conclusion of a 'culture of silence' seems untenable as it is so drastically at odds with a 79% reporting rate. This appears to be a clear case of these authors being misled by the 'whistle-blowing-silence dichotomy'. A result of this dichotomy is the non-recognition of alternative behaviours that individuals may undertake, which do not require whistle-blowing disclosure, but cannot either be defined as 'silence', especially as such behaviours might be effective in preventing and ending wrongdoing by others.[14]

Given the long-standing existence of evidence to the contrary, it is surprising that an alternative concept to organisational silence is yet to appear which more accurately captures and represents the realities of staff who raise concerns, only for those concerns to be ignored. In the next section, we introduce the term 'Deaf Effect' as a means of counter-balancing the debate which until now been dominated by a focus on employees' silence.

THE 'DEAF EFFECT'

The term 'Deaf Effect' has its roots in management and information studies literature, being defined[15] as occurring 'When a decision maker doesn't hear, ignores or overrules a report of bad news to continue a failing course of action' (p.23). Information technology project management failures provide a clear example and consequences of the deaf effect. For example, the UK Child Support Agency spent £456 million deploying an electronic support system regardless of numerous staff concerns about defects within the system. The defects resulted in a 50% increase in complaints from clients and 36 000 cases being 'stuck' in the system. These system failures were eventually implicated in the closure of the agency.[15]

Disregarding employee concerns represent a serious problem and we suggest that it is important that mechanisms which cause this effect be properly identified and conditions that predispose this effect to occur be understood. It is notable that employee concerns have been ignored by all that should have an interest, including academics and practitioners, be they clinicians, managers or policy makers. We therefore propose that the phenomenon of the deaf effect or, as we term it hereafter, 'organisational disregard' is worthy of further attention from policy makers and researchers so practitioners can take action to ensure that reports of poor care or failing services are attended to and further public suffering experienced individually by patients, or on the large-scale seen at Mid Staffordshire, is avoided.

DEAFENING SILENCE: IS THERE A LINK BETWEEN THE ORGANISATIONAL DISREGARD AND ORGANISATIONAL SILENCE?

Rather than looking at silence, organisational disregard and whistle-blowing as separate constructs, we propose instead that these are intertwined phenomena. Figure 1 illustrates how individual and organisational disregard for concerns being raised leads to silence that may be detrimental to both individual and organisation. Alternatively, the process whereby organisations that value the employee voice become learning and improving organisations is also demonstrated.

Examples from employee surveys undertaken in Norway and the UK offer support for the relationships illustrated in figure 1 among employee voicing concerns, organisations listening (or not) and whether organisational learning and improvement occurs. In Norway, 76% of health and education sector employees raise concerns when they observe wrongdoing in the workplace, a very high proportion compared with whistle-blowing in the USA and UK.[16] The reasons for such a high proportion of staff reporting concerns may be better understood when we take 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.

In comparison, in the UK, there appears to be reluctance about raising concerns among some staff, with reports also of staff concerns not being listened or responded to and fears about victimisation occurring in the wake of raising concerns. For example, a survey[17] of clinical and non-clinical staff in the NHS (n=10 350) demonstrates that 54% did not report concerns due to a 'belief that the issue won't be taken seriously or nothing will get done' (p.13). Additionally, a recent survey[18] of 8262 nurses found that 44% reported worries about victimisation or reprisals mean that concerns are sometimes not raised. Organisational disregard for employees who raise concerns can therefore inhibit employee voice and may put a strain on individual employees because they may

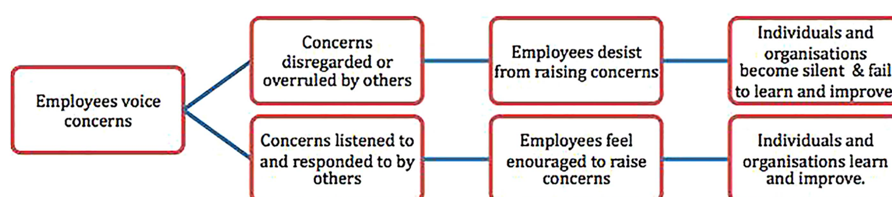

Figure 1 How the opposites of organisational disregard and silence, listening and voice can lead to failing or learning organisations.

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feel gagged and less satisfied with their ability to influence their work environment.

Recommendation 12 of the Francis Report (see box 1), which instructs organisations not only to encourage but to *insist* that staff report concerns, implicitly recognises that the decision by employees to raise a concern will be influenced by, among other things, whether their colleagues are likely to listen and respond, or not.

It has long been established that organisational failings are often preceded by an 'incubation period',[19] a time during which concerns raised by staff, if listened to or accepted by colleagues, could have averted disaster. We believe that a related process fundamental to our understanding of organisational failings is the idea of 'contagion'. In other words, if employees are ignored when one concern is raised, this can lead to silence about a range of other concerns.

The key point therefore is that silence/voice may spread, and become the norm, because organisational disregard/listening affects the relationship an individual has with others in the organisation. Weakened ties between front-line staff and managers, for instance caused by staff feedback not being responded to in one area, may result in a deterioration in the level of trust and a reduction in the probability of speaking out in another whereas strengthened ties may result in the opposite response.

However, it is also worth remembering that the action of employees speaking out, or not, can be strongly influenced by hierarchical and related status difference existing *within* professional groups such as medicine (eg, surgeons and anaesthetists), *between* groups (eg, clinicians and non-clinicians, doctors and nurses) and not merely between 'front-line' staff and 'managers'. A recent UK study[20] usefully exemplifies the differential status accorded to those who occupy similar positions within a hierarchy. One example in particular describes how radiographer managers concerns about managing their departments were ignored at a meeting by a radiologist manager who dismissed the concerns as contributing to the 'pointless bureaucracy' that wasted doctors' time, a move which also served to reinforce the subordinate position of radiographers in relation to doctors (radiologists).

Such disregard for colleagues' concerns are particularly worrying given that it is widely known that safer healthcare organisations emerge when leaders strive to overcome traditional power and status dynamics by soliciting and positively responding to all employees' concerns.[21] Organisations should thus demonstrably promote and value the importance of staff listening and speaking-out across both vertical (eg, staff nurse speaking to matron) and horizontal (eg, clinical director speaking to clinical director) status boundaries as a positive response reinforces to employees that they are safe to speak out, which in turn promotes regular critical upward feedback.[21]

The UK government have recently recognised prominent healthcare whistle-blowers via the Prime Minister's New Years Honours List 2014 in what appears to be a tacit recognition that a whistle-blower's experiences (negatively or positively) have strong effects on others' willingness and likelihood to raise concerns in the future. Similar developments that stand in direct contrast to how most whistle-blowers have been treated in the past include healthcare regulators and NHS Trusts in England recently recruiting whistle-blowers as professional advisors and 'cultural change' ambassadors. These are highly symbolic acts of recognition that clearly seek to reinforce both the preferred behaviours of healthcare employees and how organisations react to those who raise concerns.

Although prime ministers and NHS chief executives do not have a monopoly on the creation of a new organisational culture of listening, it remains to be seen whether the words and deeds of national leaders and institutions help to overcome the long established inclination within healthcare of suppressing and ignoring employee concerns. The lack of appointments and awards for those who have created safer healthcare by *listening* and *responding* to others' concerns is notable and reflects a dearth of such examples. One test of whether the words and deeds of senior leaders have changed the historical culture of organisational disregard in UK healthcare will be the extent to which future awards and appointments are bestowed upon those rewarded for listening and responding to the concerns of employees.

Box 1 Recommendation 12 of the Francis Report[2]

Reporting of incidents of concern relevant to patient safety, compliance with fundamental standards or some higher requirement of the employer needs to be not only encouraged but insisted upon. Staff are entitled to receive feedback in relation to any report they make, including information about any action taken or reasons for not acting.

CONCLUSIONS

In recent years, a substantial body of research has emerged that explores employee whistle-blowing both from the perspective of the organisation and the individual employee. However, many questions remain unanswered, which in part may be due to a tendency by policy makers and researchers to oversimplify the inherently complex and often concealed actions and interactions between those who raise concerns and their work colleagues. The binary concepts of whistle-blowing and silence are inadequate as they miss the important point that workplace concerns are raised in a multitude of different ways and contexts. As a result, staff and organisations are labelled as silent when, in fact, they are not.

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We do not question the need for research into why employees remain silent when confronted with wrongdoing. However, we suggest questions should also be posed by researchers and policy makers about organisational disregard for concerns, especially as we know that refusing to act on the concerns of employees frequently results in opportunities being lost that might otherwise reverse rapidly deteriorating standards of care. Following the Mid Staffordshire Public Inquiry, Robert Francis extensively discussed the need to reshape the workforce culture of the NHS, highlighting the need to restore trust between those delivering frontline care and their managers.

One of the many recommendations[2] within the inquiry report suggests NHS organisations should introduce a 'cultural barometer' (p.1696) to assess the strength of the relationship between frontline staff and managers based on the degree to which feedback from frontline staff is listened to and built upon to ensure excellence in patient care. Being listened to can positively impact the way that staff feel—about their jobs, their colleagues and the organisations they work in—and has a demonstrable impact on efficiency, financial performance and the quality of patient care.[22] Thus, it is important that both the mechanisms that cause organisational unresponsiveness be identified as well as the conditions that may predispose individual workers to stay silent, so that action can be taken to ensure that employee concerns are raised *and* attended to effectively and fairly.

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